Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death /Month **Physician** Mary Lillian Porter QL /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 T F 578-30-9650 JUNE 3, 87 Director 1923 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ 1 X Yes 2 □ No Director ral", or Items 23a or 28a-f s Examiner must be notified MD BALTIMORE EDGEMERE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2306 RUTH AVENUE death Funeral 21219 USA Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
nnt: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give δ 1 ☐ Yes 2 👿 No Specify Specify: nan "natural", Medical Exan 3 XWidowed 4 ☐ Divorced Year or Dates: BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DIETETIC SERVER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM SPENCER SHORT ၉ MARY L. DIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) GLORIA PORTER/DAUGHTER 2306 RUTH AVE. BALTIMORE, MARYLAND 21219 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Pages ' Department of It Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PK. 4-28-2011 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 9 torcon 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Inset and Death shock, or heart failure. List only one cause Immediate Cause (Final disease or condition **Physician** mirrotes /Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): g physician and as the burial-transit Exami certificate be executed Box 68760,% that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death requires that the death 3 Ectopic pregnancy ò in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 □ No P.O. detached the Š Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed δ, Division of Vital Records. should be 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 has ERTENSION The 1 Yes 8 No 1 🗌 Yes 2 🗌 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 \(\sum \) Nursing Home 1 🗌 Yes 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this funeral Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. 28d. Describe how injury occurred Certification: (Month, Day Year) or Attending injury Natural 5 Pending investigation М 1 🗌 Yes 2 🗌 No the 1 ∠ □ Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) o completed cause of death (Item &3a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) APR 2 7 2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 29d per dr., g914,04/2/2011dhb
Registrar Registrar Registrar Reg. No. 1. Defedent's Name (First, Middle-Last) 2 Date of Death Day **Physician** urnell 21:45 PM 2011 21 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore St Agus Hospita (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age **Funeral** Days 1 1 M 2 F Months Hours 229-30-2290 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Midical Evaluation must be a villing at MD 1 **So**es 2 □ No Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number usA 21216 2210 Avenue Completed by Funeral vuld be filed within 72 hours after death Mental Hygiene. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done life, DO NOT use retire Elementary/Secondary (0-12) Cottege (1-4or 5+) Daltimor 17. Father's Name (First, Middle Be permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked, any injury or other traumatic evanse. ercu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Type. Print) (Husband) Avenue, Baltimore, 21216 and 20a. Method of Disposition 20b. Place of Disposition connetery, cremato 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Berlin 2-2011 4 Donation 5 Dother (Specify) 21. Sig. at re of Funeran Service Licensee Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heat dailure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week neumonia ONP /Medical Due to (or as a consequence of) Examiner intraweek 6M2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dies to (or as a consequence of) burial-transit requires that the death certificate be executed brain tumor and Due to (or as a consequence of) P.O. Box 68760. After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical 1<idney IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an autopsy performed? 1 Yes 2 Wo 2 No the Hospital or Attending Physician: nin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wang Baltimore 2121 Ming-Hsi 900 Caton Ave. 31. Date filed (M Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		State of M	larylan		artmen rtificat			and M	F	Reg. No.		13503
Physic		1. Decedent's Name (First, Mid Chang Ok		Pak							2. Date of Dea Month April	Day 24	Year 2011	3. Time of Death 12:17P M
/Medi Examir		4a. Facility Name (If not instituti			-)		4b. City,	Town, or	Location of	of Death	1101.41		unty of Death	
Funeral		6401 Loch Ray 5. Social Security Number	en B			last birthday)	If Under		If Under		8. Date of Birt (Month, Day	h (Yoar)	9. Birth	place (State or Foreign intry)
Director		216-21-0227	1	M 2∏F	78	8 Yrs.	Months	Days	Hours	Min.	12/25/	1932	Kor	
yland		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
he Mar 8e-f	Director	MD			Ва	altimor		0-1-				10a Citiza	n of What Cou	1 🛣 Yes 2 🗆 No
with fi	D	10e. Street and Number 6401 Loch Ray	on D	12 #7	220		10f. Zip	1239				U.S		иш у г
deafh ms 23	Funerai	11. Marital Status		12. Was Deceden	t Ever in U.	.S. 13.			ispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Amer	
Baitimore, Maryland 21215-0036 permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Fur	1 Never Married 2 M		Armed Forces 1 ☐ Yes 2 🔀 If Yes, Give	No	ı	if Yes, spe∙ 1 ⊟ Yes		n, Mexicar Specify:	i, Pueno	rican, etc.)		Black, White pec <i>ify:</i>	
P hours	led b	3 ☑ Widowed 4 ☐ Divorce	ent's Edu		:	16a. Dece	dent's Usu	al Occupa	ation		- Annual Control	16b. Kind	of Business/I	Asi an
21215-0036 of within 72 hours affigiene of then "natural", or	Completed	(Specify only high Elementary/Secondary (0-12		Cottege (1-4or	5+)	/ife.	DO NOT u	se retired	during mos 1)	t ot worki	ng	0		
Hygier there		17. Father's Name (First, Middle	a. Last)			HC	omemai	ker	18. Mothe	er's Name	(First, Middle,		n Home	
land be lid be fenfal rked o	To Be	Im Tae	. ,	Moon					Yoo		То	Та	m	
Maryland od 2 should be file lith and Menfal Hy 27 Is marked oth rtraumatic event		19a. Informant's Name/Relatio				19b. Maili	ng Address	(Street	and Numbe	er or Rura	I Route Numbe	ar, City or T	own, State, Z	ip Code)
Te, N 1 and Health Hem 27		Chong Ae Folk 20a. Method of Disposition	mann	/ Daugh	20b. P	Place of Dispo	sition (Na	me of			ssex, M		21 tion - City or 1	Fown, State
Pages enf of nt: If It		1 ☐ Burial 2 ☐ Crematio 4 ☒ Donation 5 ☐ Other		emoval from State	Θ	emetery, cre natony G				04/2	6/2011	Hano	ver, M	aryland
Baltimore, permit. Pages 1 ar Depariment of Hea Important: If Item any injury or otha		21. Signature of Fureral Service	e Licen	9e		2:	2. Name a	nd Addres	ss of Facilit	ty A1	natomy	Gifts	Regis	try
		23a. Part1, Enter the disease,	Januari	inations that sauce	ad the deat				-			•	over,	MD 21076 Approximate
Physician /Medical Examiner	e.	shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	st only or	Due to (or a	13m s a conseq sufe	M5157								Interval Between Onset and Death
68760¢	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or a	is a conseq	quence of):								
.O. Box the death cert by the affendin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	il death 3 (⊒Ectopic p ⊒ Other (s,		,			23	d. Date of deli Month	very Day Year
COTGS, P w requires that been signed to should be defi	5	Part II. Other significant cond	tions cor	ntributing to death	but not res	sulting in the u	ınderiying (cause giv	en in Part I		23e. Did t			the cause of death?
	Completed	1											prior to death?	topsy findings available completion of cause of 2 No
Vital F siclen: Th certificafe irector, pag	Be	25. Was case referred to medi examiner? 1 Yes No		lospital:	*:* O	ER/Outpatie		Oth	or		Check only o	2	70th as (5-a	- 4.1
Division of Vital To the Hospital or Attending Physiclen: within 24 hours after death. To the Funeral Director After this certifica completely filled in by the funeral director.	tion: To	27. Manner of Death Natural 5 Pen	ding stigation	28a. Date of In (Month, D	ijury	28b. Time of Injury		28c. Injur Wor	y at		me Resi 28d. Describe			элу)
Divisi	Certification:	3 ☐ Suicide 6 ☐ Cou	d not be rmined	28e. Place of I building,	njury - At h etc. (Specil	ome, farm, st	reet, factor	y, office			28f Location (City or To		Number or Ru	iral Route Number,
To the Hospital or within 24 hours affe To the Funerel Dir completely filled in	edical (sician: To the bes ner: On the basis and manner	of examina									
To ti To ti comp	W	29b. Signature and little of cert	fier	101			29	~	e number			29d. Date	signed (Monti	h, Day, Year)
1			7	19	I dect "	- 02c\ (T	Dei-4	D	256	54		4/:	25/20	//
•		30. Name and address of pers	on who co	1412	O C	RAIN	3 / 1	W.	G	B	Mn	_	2106	/
St Regist	ate rar	31. Date filed (Month, Day, Ye APR 2 7 2011	ar)	32. Regis	strar's Sign	ature	* F							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $20\overset{\text{Yea}}{1}$ 3:20 PM April Pearl Parham Medical Mazie 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🕱 F Months Days Hours Min (Month, Day, Year) 4 Georgia Yrs Director 254-27-3518 46 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No MD Baltimore 10e Street and Number ems 23a or r must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Cameron Road U.S.A. 21212 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceue... Armed Forces? → Yes 2 🛣 No 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working l Hygiene. I **other than** " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Housekeeping Hospitality injury or other traumatic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2011 မ Daugtry Ossie Mae Parham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Myrtice Parham / Sister 1006 Cameron Road, Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 X Donation 5 Other (Specify) 04/26/2011 Anatomy Gifts Registry Hanover, Maryland 21. Signature of Fygeral Service Licer 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition LARYNX CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated Due to (or as a consequence of): Exami burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the and be detached f MAZIE PARHAM Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 X No 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certificated filled in by the funeral director; I **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 🗌 Yes 2 **X** No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year 32. Registrar's Signatur

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr g914 4-27-11 vt. State of Maryland / Department of Health and Mental Hygiene 13505 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pollara Physician/ -0/d Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death naryland timore 8. Date of Birth (Month, Day, Dec . 20 Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) **X**□ M 2 □ F Min. Year) Days Hours 214 44 9977 64 Yrs Director 946 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location
Baltimore 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits must be notified at **Funeral Director** MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 301 Mcmechen St. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify. Completed 3 ☐ Widowed 4 ✔ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ?7 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Steelworker Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Grace Booze Pelham Pollard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 534 Lucia Ave. Balto, Md. 21229 Dawn D. Pollard (daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date , 201 20c. Location - City or Town, State Department of I Important: If it any injury or or once. cemetery, crematory or other place)

Green Mount Crematory 1 Burial 2X Cremation 3 Removal from State Balto Md. 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Eacility Calvin B. Scruggs Funeral Home 1412 \mathbf{E} Preston St. Balto,Md. 23a. Part 1. Enter the disease, or complications that caused t deth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspuation disease or condition Medical resulting in death) Dile to (or as a consequence of): Examiner Can Unknown Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events ed by the attending physician and detached for use as the burial-transit Exam Pasitic unknown Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Records, P.O. cate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? After this certificate 2 🗌 No 1 🗆 Yes 1 Tyes 25. Was case referred to medical examiner? **Division of Vital** Hospital or Attending Physician: Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: ျ 1 🗌 Inpatient 2 🛍 ER/Outpatient 3 🗐 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work 1 🗌 Yes 2 🗌 No Investigation Could not be Accident within 24 hours after deatl To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 13011 D0045590 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blyd MD 21230 Joselyn Hous IIII Washington Baltimore 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 13506

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death 508 Physician/ JOHN 2611 М Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and nu **Examiner** MONTGOME? HOSPITAL BETHESDA SUBURBAN . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Months Hours 12/19/19 85 Georgia **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 No Chevy Chase Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or must be n Funeral 20815 United States 104 Oxford Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give WW II
Year or Dates. ō 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural", Completed 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Manatone. College (1-4 or 5+) Elementary/Seconday (0-12) Service Officer Foreign Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Marvin Banks Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Oxford Street, Chevy Chase, Maryland 20815 Perry / Wife Α. Marly 20a. Method of Disposition 20b. Place of Disposition (Name of April 22, Montgomery or other place) 1 Burial 2 X Cremation 3 Removal from State 2011 Bethesda, Maryland 4 Donation 5 Other (Specify) Inc. Crematorium, 21. Signature of Fun Al Service Licenses . 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHLERO SCLEPOTIC CORONARY YASCULAR Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner FEMUR WITH OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine m_D Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 Hospital: 2 No ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending FALL 15 Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 3 ☐ Suiciae 4 ☐ Homicide 28e. Pice of Injury -At home, farm, street, factory, office determined 5 2 V5 WEST CEDAR LANG BETHESDA building, etc CARRIAGE HILL Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Mandon M.D. D0060422 nd address of person who completed cause of death (Item 23a) (Type, Print) 8000 old Georgeton Road Bethesda MD 20814 JENNIFER MERRISON, M.D. APR 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner salt more Kandalls FUTURE CARE OLD COURT town Birthplace (State or Foreign County) If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day) **Funeral** Months Days Hours Year) Min 220-22-437 1 □ M 2 □ Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, I'm Medical Evans and another traumatic event, I'm Medical Evans and Ev 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Nes 2 No Completed by Funeral Director nou MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 11517 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 ☑ No Specify Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, L Be 2 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or Injury or 5 Other (Specify) 4 ☐ Donation Funeral Service Lic 22. Name and Address of Facility Furero Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DEMENT disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or ultimated the cause of the c Physician/Medical Examiner Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
5 Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit etely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown COLITIS 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: of Vital 1 ☐ Yes 2 1 No 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 MNatural 5 ☐ Pending investigation 1 ☐ Yes 2 🔲 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier D57722 APRIL M.P. 2011 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. ROAD # 300 PILESVILLE MD 21208 LEONARD RICHRDSON 1838 GREENE TREE 31. Date filed (Month, Day, 32. Registrar's Signature State APR 2 7 2011 backs Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** :43 4 Martha Jane Strader APRIL 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 🕱 F Months Feb 14, **Director** 160-20-1753 87 1924 Pennsylvania Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural" or items 23a or 28a-f show the Medical Exarciner must be notified at 1 ☐ Yes 217 No Directo Maryland Baltimore <u>Owings Mills</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 858 Queens Park Drive 21117 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 Tyes 2 TNo Specify à Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ John Piovarchy Charlotte Karkosiak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 27 Robert Grant Strader / Son 858 Queens Park Dr. Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 4/28/2011 Woodbine, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Coing Home Cremation Service P.O. Pox 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, M 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TIZ FRACTURE RIGHT HEMOTHORAX 24 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): RIGHT FEMUR FRACTURE 24 HOVAS Examiner CENTERCATION APPROVED BY WEINCH, EXAMINES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HYPERTENSION Completed 1 Yes 2 No 3 Probably 4 Unknown DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 | Natural 281. Lo tion (Stree and Number or Rural Route Number, City or Town, State) APRIL 21, 2011 UNKNOWN 1 ☐ Yes 2 ☑ No 2 Accident BATHROOM 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At nome farm, street, factory, office building, etc. (Spec determined 4 Homicide PEAR DRIVE 858 DWINGSMILLS MD 2117

Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

QUEZIVS To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5HARON 10c2e

29d. Date signed (Month, Day, Year) APRIL 22

State Registrar 29c. License number

D016810

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Lucille Singleton Anna 2011 10:23 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7 High Pine Ct. Cockeysville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🗓 F Days April IO, ^(ear)1925 360-14-7318 Illinois Director 86 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 28a-f Maryland Baltimore Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21030 7 High Pine Ct. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black. White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) supervisor life & health insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ၉ Walter E. Hathaway Quinella Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth W. Singleton/son 10 Sparks Farm Rd. Sparks, MD 21152 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem GardApr. 30,2011 Timonium, Maryland 21. Signature of Funeral Service Licensee J^{22, Name and Address of Facility} John O. Mitchell IV, Funeral Services of Dulaney Valley, <u>200 E. Padonia Rd. Timonium, MD</u> 21093 P.A. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner naminomente aft Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral direction. 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) 5 Pending Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear PM M John P. Schafer 2011 4:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 9809 Gunforge Road Perry Hall 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days Hours 01/16/1918 Director 219-05-0899 93 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Funeral Director 1 Yes 2 No MD Perry Hall Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9809 Gunforge Road 21128 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 X No Completed by 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Schafer Clara Fitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Schafer (son <u> 10011 Magledt Road - Baltimore, Maryland</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🌠 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 04/26/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Day Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 XNo Hospital: 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 X Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 29c. License number f person who completed cause of death (Item 23a) (Type, Print) 2300 State Registrar

LOHN

William Silvey 04/19/2011 9367M

			Please Type or Print in Black Ind		•	
			1- For State of Maryland / Depa Cert	rtment of Health and M tificate of Death	lental Hygier	2011 13511
ď	Physici /Medi		Decedent's Name (First, Middle, Last) WILLIAM F. SLIVEY		2. Date of Death Month APRIL I	3. Time of Death 9:30P M
	Examir		4a. Facility Name (If not institution, give street and number) GILCHRIST HOSPICE CENTER	4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE
,	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 90 Yrs. 1 M 2 F 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug. 29,	ar) 9. Birthplace (State or Foreign Country) 1920 Msryland
	aryland show dat	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits 1
	th the M or 28a-f e notifie	Funeral Director	Maryland Baltimore Perry 10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	ath wi	ral	2 Brook Farm Ct. Unit D	21128		USA
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Armed Forces? If 1 □ Never Married 2 Married 1 1 Never Married 2 Married 1 1 Never Married 1	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes ※ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
b 1215-0036	in 72 ho 1 "natur ledical I	Completed by	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of worki O NOT use retired)	ing 16b.	Kind of Business/Industry
212	filed withir Hygiene. other than ent, the M	mo	Elementary/Secondary (0-12) College (1-4or 5+) Boo	ok Binder	В	Book Manufacturing
Maryland	should be filed and Mental Hygis marked other umatic event, ti	To Be C	17. Father's Name (First, Middle, Last) William Slivey		Marshall	len Surname)
Mar	d 2 sho th and 7 is ma trauma			g Address <i>(Street and Number or Rure</i> rook Farm Ct. Unit		
	s 1 and 2 f Health item 27 i		20a. Method of Disposition 20b. Place of Dispos			Location - City or Town, State
imo	Pages ment of Hants of Hants of Hants of Hants or of hants ore of hants or of		MABuria: 2 Ucremation 3 Unemoval from State		2-2011 B	Baltimore, Md.
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Lassahn Funeral	Home.	W.L. 03.000
۲	1987		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	7401 Belair Rd. r the mode of dying, such as cardiac of		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Duw (or as a consequence of):	racture		Onset and Death
18.	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Eine Underlying Cause (Disease or injury that initiated events resulting in death) Last			7d
68760	ficate be ex physician s the burial	- CS	Due to (or as a consequence of):			
.O. Box	that the death certificate I ned by the attending physis detached for use as the b	Physician/Medic		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ds, P	88 50 80	by	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.		o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknown
COL	tw requir s been si should b	letec	<u> </u>	W	24a. Was an	24b. Were autopsy findings available
II Re		Completed			autopsy performed1 1 Yes 2 1	prior to completion of cause of death?
Vita	clan: ertific	Be	25. Was case referred to medical examiner? 150 Vas 20 No. Hospital:	Othor	(Check only one)	
0	dir	7: T	27. Manner of Death 28a. Date of Injury 28b. Time of		me 5 Residence 28d. Describe bow in	
ion	Attending F r death. ector: After by the funera	atior	1 □ Natural 5 □ Pending (Month, Day Year) Injury 2 1 Accident investigation A> 1 S ZCII UNUNCUM	Work?	fai	
Division or Vital Records,	i ji fe d	Certification:	3 Suicide 6 Could not be determined 28 Place of injury. At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Str Perry HCU	and Number or Rural Route Number ale 2 D B COGKETAM RC
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) Check only one)			
	To the vithin To the compl	Me	29b. Signature and tale of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
	11		Character MV Deputy	D18667	A	pr: 21, 2011
	1911		30. Name and address of person who completed cause of death (Item 23a) (Type, PP)		nville, N	1951063
	Sta Registr	_	31. Date filed (Morky, "bay," Year) 32. Remarks Signature 32. Remarks Signature	arkel	,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death Ponth R 16:20M 201 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 10–23–1942 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X F 67 Tennessee 409-68-2576 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 😿 No Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code U.S.A. 11449 High Hay Drive 21044 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 😿 Married 1 ☐ Yes 2 🕱 No Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James P. Parker Trousdale Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Huber Skinner (Husband) Columbia, Maryland 21044 11449 High Hay Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Columbia Memorial Pk. 4-30-2011 | Clarksville, MD 22. Name and Address of Facility 21. Signatur Witzke Funeral Homes. Inc. 5555 Twin KNolls Road Columbia, MD 21045 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease Immediate Cause (Final letastanc agendaducinon disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

ral", or items 23a or 28a-f s Examiner must be notified

"natural",

alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med

Department of Health a Important: If item 27 is any injury or other tran once.

Medical

Examine physician and as the burial-trans Physician/Medical use as signed by the att þ should be Completed page 2 certificate has Be မ After this funeral Certification: s after death filled in by the

or Attending Physician: The law requires that the death certificate be executed

the Hospital 24 hours a

within 2 To the I

Box 68760,

Division of Vital Records, P.O.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

29c License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

Lauven YV 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie



11-02903 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles O. Smith State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 1630 hrs Medical Examiner April 16, 2011 Charles Smith, Jr 0. c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Cheverly PG Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. 8 irthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days oreigMaryland Hours Months Director 05/15/1990 215-29-1735 1X M 2 F 20 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No , or items 23a or 28a-f show must be notified at once, Upper Marlboro MD PG Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 911 Andean Goose Way USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 8lack If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married Black 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 No specify: Specify: the Medical Examiner þ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Warehouse Clerk Safeway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, Charles Odell Smith, Sr. Amanda Mae Mackall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda M. Smith - Mother 911 Andean Goose Way; Upper Marlboro, MD 20774 If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 04/25/2011 Owings, Maryland Ward Memorial UMC 4 Donation 5 Other Specify 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 4594 Beech Road; Temple Hills, MD Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** 8etween Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease ≛xaminer or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examir (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit sician/Medical AMENDED item 1 per me,g915 5-17-11 sm UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of deliver 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the 1 Live birth Day 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available certificate has been 24a, Was an prior to completion of cause of autopsy death? performed? ✔ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) or Atteoding Physician: Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Inpatient 2 Other Nursing Home 5 Residence 6 Other: this 1 ✓ Yes 2 No After 1 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Apr 16, 2011 Subject shot by police 1 Natural 1444 hrs death. 5 Pending 1 Yes 2 ✔ No Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Fuoeral Dire 3 Suicide 6 Could not be or Town, State) 13717 Hotomtot Drive, Upper Marlboro, MD (Specify) Grassy area determined 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Che one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 17, 2011 O.C.M.E. OCME 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner Mary G. Ripple MÓ. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Re strar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 17:03 PM STUKES -VAN PRI 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □xM 2 □ F Maryland 60 Mar 26, 1951 Director 213-54-4053 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Nes 2 No Director N/A **Baltimore** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip-Code 1716 Cole Street 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>გ</u> Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) B & O Railroad Elementary/Secondary (0-12) College (1-4 or 5+) Railroad Employee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gardenia Stukes James Stukes ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1200 Stewart Street Baltimore, Maryland 21230 Jermaine Stukes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland 04/28/11 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failere. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) erebral EDEMA **Physician** 2 day 5 /Medical Due to (or as a consequence of) Examiner INTRACRANIAL HEMMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of, attending physician and of for use as the burial-transit HYPERTENSION The law requires that the death certificate be executed Due to (or as a consequence of): ナのメートのメール Records, P.O. Box 68760, Physician/Medical COCAINE USE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No be detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 2 2 No 3 Probably 4 √Unknown 1 TYes Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 2 No 2 🗌 No 1 ☐ Yes 1 TYes Division of Vital 25. Was case referred to medical examiner? or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 🗌 DOA ည this funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 M Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, after 4 Homicide City or Town, State) within 24 hours a To the Funeral D the Hospital 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 21,2011 RES-OOC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MASSELINK 4940 Eastern Avenue, Baltimore, MD, 21224 WINSTON 32. Regi**a**rar's S State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1.50 AM Medical (if not institution, give street and number Examiner City, Town, or Location of Death 4c. County of Death BALTIMONE **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 222 1 M 2 M Min. **Director** er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married b ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced PLAC Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State BANDA/15TOWN 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liv Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a c sequence of): disease or condition Medical resulting in death) **Examiner** MERTEN Sequentially list conditions, Examine day Lang to Translations of the Cause (Disease or iinjury Due to for as a consequence of that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 🗆 Yes 2 No 3 🗆 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed after death.

Director: After this certificate | 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XNO 1 Tes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1. Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 21328 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

4001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Edith Catharine Tuck 2011 8:30 \mathbf{A}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring 802 Caddington Avenue Montgomery If Under 1 Year If Under 24 Hrs
Hours Min. 8. Date of Birth (Month, Day, Ye. July 24, Social Security Number 6. Sex 7. Age (In yrs. last birthday, g. Birthplace (State or Foreign **Funeral** Year) 1926 Austria 1 M 2 🔀 F Director 523-38-0683 84 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Montgomery Silver Spring 23a or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 802 Caddington Avenue 20901 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" 3 XWidowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Richard S. Karp / Executor 4002 Fox Valley Dr. Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/26/2011 Final Journey Crematory Woodbine, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 23a. Part 1. Enter the Morase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Obstructive Lung Disease years Medical Due to (or as a consequence of) Examiner years Sequentially list conditions Examine It any leading to Immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nonsectionne of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar for use as the buris Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No 2 🗌 No 1 Yes of Vital funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DCA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Division s after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the D50987 aum Name and address of person who completed cause of death (Item 23a) (Type, Print)

HIMF, D MANAN MO 1500 FOREST 9 Ren Silver 5 pmg mg 0910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Physician/ APRIL ľð, 2011 MALCOLM TEMPLEMAN 11:47 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth MARCH 5, 1931 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F 579-82-4327 48 WASHINGTON, DC **Director** Usual Residence of Decedent items 23a or 28a-f show ier must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The start: If item 27 is marked other than "natural", or items 23a or 28a-f sho itny or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No MARYLAND PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2610 KIRKWOOD AVENUE 20782 UNITED STATES "natural", or item ledical Examiner n Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NONE 12 DISABLED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MALCOLM TEMPLEMAN LOUTISHIA THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUTISHA T. TEMPLEMAN/MOTHER 811 SUMERSET PLACE, HYATTSVILLE, MARYLAND 20783 20b. Place of Disposition (Name of Department of F Important: If ite any injury or otl 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) GEORGEWASHINGTON CEM. 4/16/2011 ADELPHI, MARYLAND Simature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TOBACCO ABUSE UNKNOWN Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s performed? Yes 2 X No death? 2 No after death.

Director: After this certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ျ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending XNatural Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 9b. Signature 29c. License number 29d, Date signed (Month, Dav. Year) D36475 APRIL 2011 10 and address of person who completed cause of death (nem 23a) (Type, Print) AMES ROSENTHAL, M.D. 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND 20912 Date filed (Month, Day, Year) 32. Registrar's Signature State **APR 27**

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ Day 10:04 A M Catherine Patricia Toomey April 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 5174 Brightleaf Court Rosedale Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Days Hours Min Nov. 11 Director 087 28 6579 75 New York Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Rosedale Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5174 Brightleaf Ct. 21237 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Alyuois Casey Catherine Margaret Hickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Dwyer (Daughter) 10 Quarts Garth Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1

Burial 2

Cremation 3

Removal from State permit. Page Department of Important: If any injury or Bayview Crematory Inc. 4/26/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ COMOUNT NEM Medical resulting in death) Due to (or as a onsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🎛 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pendina injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Pheldan Miller, M.C. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9110 Philadelphia

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State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ April 26, Mary Dolan Thompson 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Assisted Living Montgomery Sandy Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Min 1 🗆 M 2 🕱 F January 20, 1921 West Virginia Director 90 Yrs 232-20-3998 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Sandy Spring 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1612 Hickory Knoll Road 20860 Apt. 1 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. "natural", or iter 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced If Yes, Give Completed White WWII Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Administration Nursing other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental P ပ James Joseph Dolan Magdalene B. Tuefel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Milly Spector/Friend 3148 Gracefield Road Apt. T25, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 09/07/2011 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 21. Signature of Funeral Service Licensee

Hou on M. Should Robert A. Fumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Metastatic Breast Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). and -tran Due to (or as a consequence of) resulting in death) Last Physician/Medical phys the k attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 | Haknowa ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Obstructive Pulmonary Disease as e 2 page performed? Yes 2 X No this certificate 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living 1 Yes 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending within 24 hours after death.

To the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) μD D43202 April 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3305 North Leisure World Boulevard Charlene Ozanne-Blankfard, M.D. Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** ownes 2347 PM earnor Howard 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 0.7 - 2.5 - 1.947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-14-1267 1 □ M 2 🛛 F Director 63 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "netural" or itemated. 10b County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5907 Radecke Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No <u>ک</u> Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) contractor Elementary/Secondary (0-12) College (1-4 or 5+) 10th Environmental Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Howard Emily Reed မ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5907 Radecke Ave.Balto. MD 21206 William Townes Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Carmel CEM. 04-30-2011 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗀 Removal from State Balto. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip A. Weatherford FS PA 21. Signatu 2431 E Oliver Street Balto. MD 21213 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCVD disease or condition ong standing /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) d by the at detached f Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Nonknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has b autopsy performe 1 ☐ Yes 2 ☐ No 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 R/Outpatient 3 DOA Certification: To funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident 1 🗌 Yes 2 🗌 No filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P-0061115 April 24, 2011

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State Registrar Startin Pinth, m

31. Date filed (Month; Day, Year) 32. sistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dun A. Sals

ORIGINAL

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23^{Day} 0^{Month} Physician/ 2011 7:38A Denise Joyce Tuggle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/ABaltimore 5461 Cedonia Ave. Apt B4 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** New York 1 M 2 XF Months Davs Hours 0871777953 Director 214-58-5570 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County notified at 10c. City. Town or Location Director 1 Yes 2 No Baltimore N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o event, the Medical Examiner must be Funeral with 1 items 23a U.S.A. 5461 Cedonia Ave. APt B4 21206 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ō by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black and Mental Hygiene.
is marked other than "natural", 3 - Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Union Memorial Elementary/Seconday (0-12) College (1-4 or 5+) Financial Counselor Hospital 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filk Department of Health and Mental I Important; If item 27 is marked of any injury or other traumatic eve Dallas Chapman Mozelle Bagby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1065 Bayner Rd., Baltimore, MD 21221 Audrey Tuggle (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD on-site Crematory04/27/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ocensee ²Joseph^{dd} H^{s of} Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, N PA MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between 100 Onset and Death Ph_sician/ cancer letasta disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical certificate be Records, PiO. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed' Hospital or Attending Physician: The 1 Yes 2 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? furieral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Affer 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours at er death

To the Funeral D rector: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51788 4-23-11 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD POIK Rd # 300 6115 Falls MD Tim 31. Date filed (Month, Day, Year) State Registrar OHMH 17 Rev 7/2009

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2021 State Registrar only one)

SAMEER

31. Date filed (Month, Day, Year), APR 27

29b. Signature and title of certifier

AMMEN

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KADRI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

backer

29c. License number

0101247723 (VA)

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25 Day April 20 1°1 3:34 Рм Vigliotti Vincent Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 2737 Cassedy Street 8. Date of Birth 9. Birthplace (State or F (Month, Day, Year) 1953 Connecticut 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Days 1 🕅 M 2 🗆 F Hours 042-42-8829 Director 57 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2737 Cassedy Street 20910 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian Black, White, etc. by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Defense Program Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bonaldo John Vigliotti Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2737 Cassedy Street, Silver Spring, MD 20910 Francine Marie Vigliotti/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date April 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland Montgomery Crematorium Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01596 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Priysician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 🗌 Yes 2 🗌 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner?

1 Yes 2 X No Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one) Certifying Nurse Practioner: To the best ny knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) April 26, 2011 D0017135

State Registrar

Barke

5450 Knoll North Drive #250, Columbia, MD 21045

and address of person who completed cause of death (Item 23a) (Type, Print)

Lawrence Swink, MD

31. Date filed (Month, Day, Year) APR 2 7

11-02 Kimba	all Dale Wa			ease Type Stat	e or Print i ll e of Maryla	and / Dep	I ndelib partme e <i>rtifica</i> :	nt of H	lealth a	and M	ental H	ygiene	gible	201	•	13524
`			Registrar 1. Decedent's Nam	- (Final Middle I			erunca	te or L	<i>Jeann</i>			2. Date of Dea	eg. No.		3 7	Time of Death
Medi	Physicia cal Exami											Month April 18, 2	Dav	Year		2205 hrs
D	}		Kimball I 4a. Facility Name ((if not institution,	give street and nu	ımber)		4b.	City, Town,	, or Locat	ion of Death			County of De	eath	
6			Johns Hopl	kins Hospital					Baltimore					N/A		
de	Funeral		5. Social Security	50 DOM	Sex	7. Age (In yrs	s. last birtho		If Under 1 \	_	Jnder 24Hrs ours Min.		•	Fo	reign	
	Director		220-82-34	177	X M 2 F	49		Yrs.				June	5 , 1	961 W	ash	Ington D.C
	şu ş		Usual Residence o 10a. State	10b. County		10c. Ci	ity, Town or	r Location								d. Inside City Limits
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	with the Maryland is 23a nr 28a-f sho e notified at once.	Ω	635 Nort	h Robin	son Stre	et			21205				USA			
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	er dea		3 Widowed		1 Yes	2 X No		1 Ye	es 2X	No spe	cifv:		- 1	Specify: Bl	ack	
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5	within iene.	Completed	12th gra	ade			Ent	repre	eneur	Lana	At and a Manual	(First, Middle,		ivate	Indi	ustry
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200	DAILUMOIN, MID X1X13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "satural", or items 23a nr 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	To B	Theolive 19a. Informant's Na	M. Wash ame/Relationship	1ngton (Type, Print)		19b.	Mailing A	ddress (Si			Rural Route Nu	mber, Cit	ty or Town, S	tate, Zip	Code)
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-	f Heal		20a. Method of Dis	sposition		208	b. Place of	Disposition or other		f cemetery	' ,	Date	20c. L	ocation - City	y or Tow	n, State
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-	√/Medical		ailure. Liv or	nly one cause or	each line.	e Subai										Between Onset and Death
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Û	certifi certifi anding use as	cian	past 12 months		1 Live t	oirth nant at time of	death 5	Fetal	death (Specify)	3E.c	topic pregna	ancy		Month	Day	Year
Š	box e death the atte	hysi	1 Yes 2	No 9 Unkno	9 Unkn	own		Other	(Opeany)	Contract Contract						
	· # > 5년		Part II. Other sign	ificant condition	s contributing to	o death but no	t resulting i	in the und	erlying caus	se given i	n Part I.		_			cause of death? 4 Unknown
3	Ords, F.C. w requires that as been signed I should be deta	Completed by								_		24a. Was				y findings available
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2	cian: The certificate ector, page	Co							00.00	(D-	all (Obsal)	1 Yes	2 N	0 1 🗸	Yes	2 No
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5	ding Phy L. After th funeral o	. To	1 ✓ Yes 27. Manner of Dea	2 No	28a. Date			me of Inju		Injury at V	Vork?	28d. Describe	how inju	ıry occurred		
3	Tendin ceath. inr: A	atior	1 X Natural 2 Accident	5 Pendin Investig	g	i, Day, real)]		1[Yes 2	No No					
	or At or At after d Direct	Certification:	3 Suicide	6 Could	not be 28e. Plac	ce of Injury - At	home, farr	m, street, f	factory, offic	ce buildin	g, etc.	28f. Location or Town,		nd Number o	r Rural F	Route Number, City
	spital hours filled	S	4 Homicide 29a. Certifier	determ	(0,000,00)											
(1)	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only ' 📖		sician: To the be ner:On the basis											iuse(s)
	To To	Mec	29b. Signature and	<u> </u>	and manner s	stated.			29c. Lic	ense num	nber		29d. (Date signed	(Month,	Day, Year)
			KIF.	()	Tem.	1 - 1-	2010	Lel a	O.	C.M.E.			Apri	il 19, 2011		
Nov.	S.		30. Name and add	ress of person w					3							
17	1	¥ 8	Patricia Arc	onica-Pollak		ant Medica		ner 1	11 Penn	Street,	Baltimor	re, MD 2120)1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Steven vynite	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	13525
Physician Medical Examine	1. Decedent's Name (First, Middle, Last) 2. Date of Death North	me of Death 222 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4200 Rokeby Road Baltimore	la
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace	e (State or
Director	214-02-1951 1 M 2 F Annual Policy Street 29 Yrs. Months Days Hours Min. Nov 26, 1981 Country)	MD
w any	10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits
faryland 28a-f she latonce	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ith the N 23a or	101 N Monastory Aw 21229 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Inc.	idian Black
r death with the Maryland , or items 23a or 28a-f sh c.must be notified at one	1 Never Married 2 Married 2 Married 2 Married 1 Yes 2 No White, etc.	
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Interest If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once. To Be Commissed by Finneral Director	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town,) 21227 State
.도 ~ 일 듯 ㅎ !	1 Varial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Removal from State King Memorial 5 7 2011 Baltim	ore, NO
Balti permit. Departm Importminjury	21/Signature of Funeral Service Licensele 22. Name and Address of Facility Howell Funeral 4600 Liberty Heights Aug. Balt	o. MD
Physician Medical	failure. List only one cause on each line.	proximate Interval tween Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):	Deali
je je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
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fox 68760, eath certificate be executed attending physician and for use as the burial - transit sician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
). Box 687, the death certification by the attending plotched for use as the Physician//	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	
Division of Vital Records, P.O. Box 68760, fo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - trans edical Certification: To Be Completed by Physician/Medical E		
ords, F w requires to as been sign should be collected to	24a. Was an 24b. Were autopsyl	findings available
Records, The law requires fincate has been significate by page 2 should be Completed	autopsy prior to comple performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	etion of cause of
Vital Recysician: The list certificate lightector, page	25. Was case referred to medical 26. Place of Death (Check only one)	ne
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P	77 Manage of Death	
Division or spital or Attending hours after death. neral Director: After filled in by the funer Certification:	Apr 24, 2011 0217 fills 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Roll or Town, State)	oute Number, City
Di lospital t hours a uneral I dy filled	4 W Homicide determined (Specify) Local Street 4200 Rokeby Road, Baltimore, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	
	29b. Signature and title of cartifler 29c. License number 29d. Date signed (Month, Date of Control of Contro	ay, rear)
_ ,	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State	e 31. Date find (Month Day, Year) 32. Rehistrar's ligoature	
Registra	The state of the s	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	_ State	of Maryland		irtment of H tificate of D			lene leg. No. 2 A	1 12526		
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death		
	Physicia Medic		Arthur Edward West					March 2	24, 2011	2:45PM		
j	Examin	er	4a. Facility Name (if not institution, give street and nu 5814 Gwynn Oak Ave	mber)		4b. City, Town, or Baltimo	Location of Death		4c. County of Death N/A			
	Funeral Director		5. Social Security Number 218–36–4325 6. Sex 12 M 2 G	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Day	Ye 4 r942 9. B	irthplace (State or Foreign Marby La ho		
	nd te	7	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	cation				10d. Inside City Limits		
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212	within jiene.											
Maryland 21215-0036	be filed v lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Buck West									
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è, Z	and 2 Health tem 27		Troy Arthur West/ Son 20a. Method of Disposition	20b. Pl					Jersey 07			
Baltimore,	t. Page 1 rtment of rtant: If i	1 Removal from State 4 Donation 5 Other (Specify)										
Bai	permi Depar Impor any ir once.		21. Signature of Fun all Service Lily note		52 52	Name and Addres	erstown R	tman-Hai d Baltir	rris funer more,Maryl	and 21215		
		6	23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on a	t caused the death	. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between		
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	Examiner		S,		ardi	ar Dec	eage.					
	d sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury									
	xecute n and al-trans	edical Examiner	that initiated events C. ———	o (or as a consequ	ence of):							
9	te be e hysicia he buri	dical	d									
687	ertifica ding pl			utcome of pregnar					23d. Date of	delivery		
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 5th bours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	in the past 12 months?	re Birth 2 Fetal egnant at time of d known		Ectopic pregnand Other (specify)	:y 		Month	Day Year		
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Rec	sician: The law certificate has t lirector, page 2 s	Som					. 110	autop perfo 1 🗆 Yes	rmed?death	Yes 2 1 No		
ital	ician: certific ector,	B B	25. Was case referred to medical examiner?			_ Oth	ace of Death (Chec					
of V	g Phys er this eral dir	e: To	27. Manner of Death 28a. Dat	Inpatient 2 : te of injury onth, Day, Year)	ER/Outpatier 28b. Time of injury	nt 3 🗆 DOA	4 ∐ Nursing Hoy y at		lence 6 Other (Sp ow injury occurred	ecify)		
ion	tending leath. or: Aft the fun	Certificate:	2 Accident Investigation		-	_M _ 1 □	Yes 2 No			D. A. D. A.		
Division of Vital Records,	al or At after o Direct d in by		4 D Hamisida datarminad 28e. Plai	ce of Injury - At hor Iding, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow	treet and Number or i n, State)	Hurai Houte Number,		
	To the Hospital or Attending Physician: The Is within 24 Horburs after death. To the Funeral Director: Affor this certificate ha completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the bonly one) 3 Certifying Nurse Practione	asis of examination	and/or invest	tigation, in my opinic	on, death occurred a	t the time, date a	nd place, and due to th	ne cause(s) and manner stated.		
	To th Vithir To th COMP	_	29b. Signature and title of certifier	Α.		29c. Licenso	e number		29d. Date signed (Mo	nth, Day, Year)		
			30. Name and address of person who completed ca	use of death (bear	23a) (Tuno 1		34176	//	0,0.1	2011		
	3,		30. Name and address of person who completed ca	9 W/	IKEL	is Aut	FA!	1 HOR	MO	21229		
	Sta Registr		31. Date filed (Month, Day, Year) 32.	Registrar's Signat	ure							

DHMH 17 Rev 7/2009

,,			For State Registrar	State of N	Maryland		artment <i>tificate</i>			and M	ental H	lygieñ Reg. N		data	0021
	Physici		1. Decedent's Name (First, Middle, Anthony R. Wri								2. Date of Month Apri.	Death)av	Year 2011	3. Time of Death 3:18P M
*	/Medio Examin		4a. Facility Name (If not institution, 10713 Willow Oa	ks Drive	ər)				Location o			4	c. County	of Death	rge's
	Funeral Director			6. Sex 7. 1 M 2 F	Age (In yrs. Ia	st birthday) Yrs.	If Under Months		If Under a		8. Date of (Month, Oct	Birth Day, Yea 7 , 1	958	9. Birthpl Coun DC	ace (State or Foreign try)
	e Maryland	Director		George's		Town or Lo	ville								0d. Inside City Limits 1 Yes 2 □ No
	3a or 2	i Dire	10e. Street and Number 10713 Willow Oal	ks Drive			10f. Zip		721			10g. (USA	What Coun	try?
350	d within 72 hours after death with the Maryland liene. I then "natural", or Items 23a or 28a-f ehow I're Mudicel Evantiner must be inclifted at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date]Yes 2. No 'es, Give 1			Was Decedent of Hispanic Origin? (Specify Y. If Yes, specify Cuban, Mexican, Puerto Rican, 1 Yes 2X No Specify:					es or No- etc.) 14. Race - American Ind Black, White, etc. Specify: Black		
9500-61212	within 72 ene. then "na'	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give life. l	dent's Usual Occupation kind of work done during most of working DO NOT use retired) S Operator					16b.		usiness/Ind	·
Maryland 2	9 % = -	To Be Co	17. Father's Name (First, Middle, L Mickeal Wright	<u> </u>		ьu	s ope		18. Mothe		(First, Midd		en Suman	ne)	
nary	2 shours and N is mail		19a. Informant's Name/Relationsh	ip (Type, Print)			-		nd Numbe	or Or Rura	il Route Nu	mber, City			
aitimore, n	permit. Pages 1 and 2 should be fit Department of Health and Mental Himportant: If Itam 27 is marked other traumatic even once.	. 5	Shelia Wright 20a. Method of Disposition 1 □ Burial 2 X Cremation 4 □ Donation 5 □ Other (Sp		ite <i>ce</i>	ace of Dispo emetery, cren rerdale	sition (Nam natory or ot	ne of ther place	9)	C	e, Mi _{Date} 9/201	20c.	Location -	City or To	MD 20721 wn, State Maryland
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r	Physician /Medical Examiner		23a. Part 1. Ender the disease, or o shock, or theart tailure. List of Immediate Cause (Final disease or condition resulting in death)	a Lung	sed the death. In line. Cancer as a consequ		er the mode	e of dying	, such as	cardiac c	or respirator	y arrest,			Approximate Interval Between Onset and Death
2,0078	icate be executed physician and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.												
O. BOX 62	aath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ∏Fetal t at time of de	death 3	Ectopic pro					_		ate of delive	ery Day Year
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<u> </u>	pital or urs afte sral Dir		4 Homicide determine	ned 28e. Place of building,	Injury - At hor , etc. (Specify,						City or	Town, St	ate)		al Route Number,
	the Hos nin 24 h the Fur npletely	Medical		g Physician: To the be examiner: On the base and manner	s of examinati		vestigation,		inion, dea			ne, date a	and place,	and due to	
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	le		20 Name and address of person v EIIZab Eh Pfaffenroth M.D	who completed cause . 1221 MER		23a) (Type, E LANE	,	O,MA	RYLAI	ND 20	0774				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wolfe Margaret Diane 2011 7:38A Medical Apri] 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Healthcare Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Min. Hours Mary Land (Month, Day, Year) 09/04/1942 Yrs Director 217-40-9007 68 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Fallston 10e. Street and Numbe 10f. Zip Code items 23a or ner must be n 10a. Citizen of What Country? Funeral 1811 Angleside Road 21047 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 6 þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Sales Retail other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filer tment of Health and Mental H tant: If item 27 is marked of ပ္ Glen Wolfe Hubbard Martha Marie Homer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 Angleside Road, Fallston, MD 21047 ∖Marne Harker / Daughter Department of Heals Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 04/26/2011 Hanover, Maryland 21. Signature of Aneral Servi & Licens 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Chronic Physician/ ru/monary Obstructive disease or condition resulting in death) 6 year Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leaves (Disease or iinjury Examiner Due to lor as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year 1 ☐ Yes 2 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No the Hospital or Attending Physician: The this certificate 1 Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 XNo Other: မြ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Division 1 Yes 2 No Accident Investigation 24 hours after deatle Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif D35012 Sa) (Type, Print)
Upper Chesapeake Med. Ceuter Bel Air Md. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LYNCH MD 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

78900001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day Month Apn Jan 9:394 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death Baltmore Bon Secous 40201 pol Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 😿 M 2 🗆 F Days Min (Month, Day, Year) L2/04/1949 Country) Maryland Director 214-50-5232 6 Usual Residence of Decedent or 28a-f show be notified at 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? be 23a Funeral er than "natural", or items 23: the Medical Examiner must be 1024 N. Bentalou Street 21216 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 K Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver of Health and Mental Hygier item 27 Is marked other to other traumatic event, the Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) White Veronica Darnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any injury or other trau Nathan Blue / Son 3128 Seguoia Avenue, Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 04/26/2011 Hanover, Maryland . Signature of Fundal Service Lic 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) acute myocardial infarction Medical Examine coronany Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DW honan Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has a in by the funeral director, page 2 s performed? ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiper? Hospital: 2 🗆 No Other: မ 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Tes 2 No ☐ Acciden
☐ Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check D0056240 Attending Physician Cart, mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bon Serous Hospital Cort, Battomore 2000. Breek 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_		For State Registrar		State of M	arylan	-	artmen rtificate				ental Hy	/gien Reg. N	ZUI		133	530
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APRIL				23a. Part 1. Enter t shock, or hea	the disease, or com rt failure. List only o	plications that caused ne cause on each line	d the deati	h. Do not ente	er the mode	of dying	ı, such a	s cardiac or	respiratory a	rrest,			pproxima	
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RTE	e death o	been signed by the attending should be detached for use as	Physician/M	23b. Was decedent in the past 12 t 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	death 3	Ectopic p Other (spe	regnancy ecify)	/				23d. Date of Month	delivery Da		Year
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:	DIVISION OT VITAL RECORDS, tal or Attending Physician; The law requires is after cleath.	within 24 nous are road. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not b determined		ury - At ho	me, farm, str			res 21		8f. Location (City or To	Street a	and Number or te)	Rural Ro	oute Nun	nber,
	Hospital	Funeral Funeral ted filled	Medical	29a. Certifier 1 (Check 2	☐ Certifying Phys	sician: To the best of ner: On the basis of e	my knowł	edge, death o	occured at t	he time,	date and	d place, and occurred at t	due to the ca	ause(s) and place	and manner as ce, and due to t	stated.	e(s) and m	nanner stated.
	Fo the	Fo the		only one) 3 29b. Signature and		se Practioner: To the	best of my	/ knowledge, o		ed at the License			, and due to ti		e(s) and manner Date signed <i>(M</i> o			
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Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

12500 Willowbrook Road.

Cumberland.

MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signatu

<u>Aaron Snyder</u>,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20^{Day}2011 APRIL DOREEN G. YORKE 9:03A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign FEB. 16 1 □ M 2 🗓 F Months Days 1945 GUYANA **Director** 577-70-8879 66 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at Director MD PRINCE GEORGE'S SPRINGDALE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 23a 8912 BOLD STREET 20774 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Specify: AFRICAN 1 Yes 2 No "natural", Completed 3 Widowed 4 X Divorced Year or Dates AMERICAN 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BRANCH MANAGER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည EUGENE MASHART EDITH EDWARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 8912 BOLD STREET SPRINGDALE, MARYLAND 20774 MICHELLE YORKE/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If it any injury or of once. Page 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2011 RIVERDALE, MARYLAND RIVERDALE CREMATORY 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility J. B. JERNKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the diserte, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure List only one cause on each line. 23a. Part 1. Enter the diseas Approximate Interval Between Onset and De th Immediate Cause (Final disease or condition ATHEROSCLEPOTIC CARDIOVASCULAR DISTAN Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical 09/89 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown advec to Thrive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed' 1 🗌 Yes 2 😾 No Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 x ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1X Natural work? 2 Accident
3 Suicide
4 Homicide Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certifie 29d. Date signed (Month, Day, Year) APRIL 26, 2011 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

PASSI M.D.

RAVI

31. Date filed (Month, Day, Year)

7 2011

15245 SHADY GROVE ROAD #130 ROCKVILLE, MARYLAND 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylar	-	artment of H		and Men	tal Hygie	ene	1 1	10501
			Registrar 1. Decedent's Name (First, Middle)	/ act)		Cer	tificate of D	veatn	12.0	Reg	. No. /		13534
	Physicia		Geraldine	,	pp					Month Pril	2ªy 2	2011	3. Time of Death 12:44 P M
	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, or	Location of			4c. County		
	LXaiiiii	CI	Baltimore Washi	_		enter		n Burr					undel
	Funeral		5. Social Security Number		Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. D Min (A	Date of Birth	parl.	9. Birthpl Counti	ace (State or Foreign
	Director		214-26-4228	1 □ M 2 💢 F	_	81 Yrs.	MOTITIS Days	Hours	NE	Month, Day, Ye	1929	Count	MD
7	show d at	٦	Usual Residence of Decedent 10a, State 10b. County		10c. Cit	y, Town or Loc	cation					10	Od. Inside City Limits
0	aryla la-f s ified	ect	Maryland Anne	Arundel			F	asade	ena				1 ☐ Yes 2 ☒ No
M odt	or 28	흐	10e. Street and Number				10f. Zip Code			100	g. Citizen of W	/hat Count	try?
4	s 23a ust b	Funeral Director	104 Dupont Ave	nue				211	.22			USA	
dt col	item:		11. Marital Status	12. Was Decede Armed Force		S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origi n, Mexican,	in? (Specify Y Puerto Rican	es or No-		- America k, White, e	
ည် နို	l", or xamil	d by	1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	ied 1 Tyes 2 If Yes, Give	X No		☐ Yes 2 🔀 No				Specify:		ite
3 5	atura	etec		Year or Dates t's Education	3.	16a Deces	lent's Usual Occupa	ation		16	b, Kind of Bu	siness Ind	ustry
312 182 182 182 183 183 183 183 183 183 183 183 183 183	i. an "n Medi	Completed		st grade completed) College (1-4)	or 54)	(Give F	kind of work done d O NOT use retired)		of working	1	DI Mild of Bo	omoco ma	,
7	giene giene er th t, the		Elementary/Seconday (0-12)	College (1-4)	JI 3+)		Homemak	er			Hous	sehol	d
ם ק	ental Hygiene. Ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, L		1					st, Middle, Mai	den Surname)	
Maryland 27275-0036	and a single should be man within a hous area locatif with the way hat fleath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f si other traumatic event, the Medical Examiner must be notified.		Howard Melv		:K			Anna		reiner			
Mai Mai	Lith and Me		19a. Informant's Name/Relationsh)		g Address (Street a						ode)
ရှိ (၁)	nt of Healt it If item 2 or other		Ryan L. Zepp 20a. Method of Disposition	(sc			st Summi	1			c. Location -		wn. State
imo E			1 ☐XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate C	cemetery, cren	natory or other place Cemetery	e)	April 201	27		•	West Virgin
Baltimore,	Department of Important; If any injury or once.		21. Signature of Funeral Service				. Name and Addres	<u> </u>		-			me, P.A.
ñ	and in the part of	- 1	Ill d	24 11		*	3111 Mou	ıntain		l, Pasa			
	n sician/ Medical Examiner		23a. Part 1. Enter the visease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	line. ~ 1	rotic	ar the mode of dying Burel ov	/		Diratory arrest,			Approximate Interval Between Onset and Death
٠	.xammer	P.	Sequentially list conditions, If any, leading to immediate b. Due for as a consequence of):										
~ P	ısit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due for	as a conseq	uence of):	alliton	1				Į.	
executed 9	n and al-trar	Exa	that initiated events resulting in death) Last	c. Due to (or	as a conseq		TO CITO						
5 e e e	/sicial	lical		d									
	ng phy as th		IF FEMALE:	T									
BOX	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	23c. If yes, outcor 1 Live Bir 4 Pregnar 9 Unknow	th 2 Tetant at time of	aldeath 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Dat Moi	e of delive nth	ry Day Year
dS, P.O.	en sign e d build be deta	by	Part II. Other significant conditio	ns contributing to deat	h but not res	sulting in the u	nderlying cause giv	en in Part I.	:				e cause of death? ably 4 🗆 Unknown
Mecords, The law requires	ate has be	Completed						_		24a. Was an autopsy performe 1 2 Yes 2	ed2 F		sy findings available npletion of cause of
VITal vsician:	sertific ector,	m	25. Was case referred to medical examiner?	Hospital:			h d Otho		h (Check only	one)			
OI V	this ral dir	2	1 ☐ Yes 2 🔊 No 27. Manner of Death	1 Inp		ER/Outpatien 28b. Time of	t 3 DOA Other	4 ∐ Nur		5 Residence Describe how			
	th. After fune	cate	1 Natural 5 Pending 2 Accident Investig	g (Month,	Day, Year)	injury	work'			Describe now	injury occurre		
DIVISION tal or Attendir	after dea Director I in by the	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 28e. Place of	Injury - At ho etc. (Specif)	ome, farm, stre	eet, factory, office			Location (Stree City or Town, S		r or Rural	Route Number,
) Spital	hours uneral d filled	Medical	29a. Certifier 1 Certifying	Physician: To the best	of my know	ledge, death o	occured at the time,	date and p	lace, and due	e to the cause	(s) and manne	er as state	d.
the H	hin 24 the Fu mplete	Med	only one) 3 - Certifying	Nurse Practioner: To	of examination the best of m	n and/or invest y knowledge, c	leath occurred at the	time, date a	and place, and	d due to the ca	use(s) and ma	nner as sta	
7	0 2		29b. Signature and title of certifier	X IMA			29c. License	1282	0	290	I. Date signed	(Iviontin, E	Day, Year
	a.		30 Name and address of person	to completed cause of	of death (Item	1 23a) (Type, P	rint)	,			1	100	7 ///
	0		Christopher	deBasa	MI	37	08 may	15 ta	in R	dPo	15 ade	Na.	MD 21102
	Stat Registra	C	31. Date filed (Month, Day, Year) APR 2 7 2011	32. Regi	strar's Signa	ture							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State	of Marylar			nt of He <i>te of D</i>		Mental Hy	giene Reg. No:	1111	13535
		Decedent's Name (First, Middle	e, Last)						2. Date of De Month	eath Day	Year	3. Time of Death
Physiciar /Medica	_	Gabriel Along	e						April	15,	2011	9:20 PM M
Examine	_	4a. Facility Name (If not institution	-			-		ocation of Death	1	4c.	County of Dea	th
>	*	Future Care C					ltimor					
Funeral Director		5. Social Security Number 579-15-9579	6. Sex 1 M M 2 ☐ F	7. Age (In yrs. 47		Months		Hours Min.	8. Date of Bi (Month, D Oct 2,	ay, Year)	9. Bin Co	thplace (State or Foreign buntry) unk
P		Usual Residence of Decedent		40.0								10d Inside Challing
arylar show	_	10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits 1√E Yes 2 □ No
8a-f	200				Baltimo					10- 011	zen of What Co	- 22
DESILITIOTE, IMERYIER Z I Z I 3-0030 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other treumatic event, its Modral Examinar count be notified at once. To Be Commission by European Disposer.	by runeral Director	10e. Street and Number 2327 N. Char	Les Stree	t		10f. Z	ip Code 2]	1218		iog. Citi.	USA	ountry?
deat me	ner	11. Marital Status unk	Amed 8	cedent Ever in U	J.S. 13. V	Vas Deci	edent of Hisp ecity Cuban.	panic Origin? (S Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit	
s after	oy ru	1 Never Married 2 Married 3 Widowed 4 Divorced	ied 1 ☐ Yes	2XINo live				Specity:	,		Specify: b1	
thou sture	9	15. Deceden	t's Education		16a. Deced	ent's Us	ual Occupati	on	unk	16b. Kii	nd of Business	/Industry unk
thin 72 hours at e. n. "neture!", or Medical Earth	Сотріете	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of w	ork done du use retired)	ring most of wor	king			
Man and and and and and and and and and a	0	unk	unk									
VIBICAL Montal Hy Arked oth atic event	å	17. Father's Name (First, Middle,	Last)				unk 1	8. Mother's Nar	ne (First, Middle	e, Maiden	Sumame)	unk
and Me	<u>o</u>	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Addres	ss (Street an	d Number or Ru	ıral Route Numi	ber, City o	r Town, State,	Zip Code)
t and 2 Health em 27 f		Future Care Ch	arles Vil					es Stre	et Balt:			21218
ages 1 nt of H t: if fte		20a. Method of Disposition 1 Burial 2 Cremation		n State	Place of Disport cemetery, cren	natory or	other place)	1	Date	20c. Lo	cation - City or	rown, State
DESILITION Permit. Peges Department of Importent: if it eny injury or o	i	4 □ Donation 5 ☑ Other (S 21. Signa ur of Funeral Service Ronal d		itate Vi l ector	r/ S 2	. Name a	nd Address	า ทั√aซีอลาง	1 655 W	Ba1	timore	Street
0 88558		sunvy	MACK		Ва	1tim	ore, l	MD 2120)1			1
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	each line.						arrest,		Approximate Interval Between Onset and Death
Physician //Medical		Immediate Cause (Final disease or condition resulting in death)	a	MCT (or as a consec	hsta:	nc	IW	ng CA	ncer			
Examiner		Commentation and distance	5	o (or as a consec	quence or).							
P = 0	Je I	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consec	quence of).							
ficate be executed a physicien and ts the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a consec	quence of):							
cate be exphysicien the burial	Cal		d.									
ng phy as th	U	IF FEMALE:	7									
ath cer ath cer titlendir or use	any	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 ☐ Feta	al death 3		pregnancy			1	23d. Date of de Month	Day Year
bet the death certification of the standard for use a stached for use a brivel flag.	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preg 9⊟Unk	gnant at time of one of the communication of the co	death 5	Other (s	specity)		*****			
thett		Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	nderlying	cause given	in Part I.	23e. Did	tobacco u	ise contribute t	to the cause of death?
w requires the second s	200	Human im	mune	defici	ency	VU	VU5		1 🗆	Yes 2	9N₀ 3□P	robably 4 🗀 Unknown
law re	Completed	2			V				24a. Wa	s an	24b. Were a	utopsy findings available completion of cause of
The The page	E								peri 1 Yes	formed?	death?	s 202No
ician: lician: Sertifice	Ø i	25. Was case referred to medica examiner?						26. Place of Dea	ath (Check only	one)		
Physic this can dire	2	1 ☐ Yes 2 12 No			ER/Outpatien			4 Nursing F	lome 5 Res			ecify)
After After		27. Manner of Death 1. Natural 5 Pendir 2 Accident investi	g (Mo	of Injury nth, Day Year)	28b. Time of Injury	м	28c. Injury a Work?	nt es 2 ⊡No	28d. Describe	how injur	y occurred	
Attending or death. ector: After fune by the fune	20	3 Suicide 6 Could	not be 28e. Plac	e of Injury - At h	iome, farm, str				28f. Location	(Street an	d Number or F	Rural Route Number,
a after of Direction of Directi	Certification:	4 Homicide	buil	ding, etc. (Speci	(y)				City or I	own, State		
	edical	29a. Certifier 1 Certifyir (Check only one)	ig Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurre estigation	d at the time on, in my opir	, date and place nion, death occi	e, and due to the urred at the time	e cause(s) e, date and	and manner a place, and du	is stated. le to the cause(s)
o the within To the comple	Me	29b. Signature and title of certifie					9c. License				te signed (Mor	
		▶ Tuarter 0	m mo				7) 3	5102		Apr	11 19.	2011
-		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type,	Print)	DV laz	STYLL	+ Ba	lhm	ibro m	avylano
State	9	31. Date filed (Month, Day, Year)		Registrar's Sign	ature	1	FIV LE	/ - 11.50	· pu	, ,,,,	316 111	[["
Registra		APR 28 20	11 agree	W. B.	19ans	-						

DHMH 17 Rev 1/2001

11-03117 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Allen Amos State of Maryland / Department of Health and Mental Hygiene 2011 13536 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 24, 2011 1156 hrs **Medical Examiner** Richard Allen Amos 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Gwynn Oak **Baltimore County** 2703 Gwynnmore Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign South CountryCarolina Min Director Months Days Hours 28,1950 July 229-66-6396 1XXM 2 F 60 Usual Residence of Decedent iny 10c. City, Town or Location 10d Inside City Limits 10a, State 1 Yes 2 X No s 23a or 28a-f shove notified at once. or 28a-f show Gwynn Oak **Baltimore** hours after death with the Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 2703 Gwynnmore USA Ave Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Specify: White 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 IBM 12 Management 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Anthony C. Amos Martha Burnette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 Mt. Hebron Court, Ellicott City, MD 21042 Heather Amos-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 2 X Cremation 3 Removal from State Atlantic Crematory Glen Burnie Maryland Other Specify: Donation 5 al Service Lice 22. Name and Address of Facility Ambrose Funeral Home Inc. Signature of Furie 1328 Sulphur Spring Road Arbutus Maryland 21227 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Diabetic hyperglycemic Ketoacidosis Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED attending physician a AMENDED 23a,27,g915 5-16-11 sm The law requires that the death certificate be Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 ✓ No 3 Probably 4 Unknown ficate has been s , page 2 should h 24a Wasan 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? Comi ✓ Yes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospins. ... within 24 hours after death.

To the Funeral Director: A 1 X Natural 5 Pending Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 25, 2011

Registrar

DHMH 17 Rev 1/2001

OCME 2006

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

rece 30. Name and address of person who completed cause of death (Item 23a)

Victor Weedn MD JD

31. Date filed (Mon a Man, Y

Speck

Assistant Medical Examiner

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02959 State of Maryland / Department of Health and Mental Hygiene Paul Anthony Anderson Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day April 19, 2011 1140 hrs Paul Anthony Anderson **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel **Curtis Bay** 96 Weldon Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 35 07/29/1975 Country) Maryland Director 214 04 1800 1 X M 2 F Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Maryland N/A Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

In: If item 77 is marked other than "matural", or items 23a or 28a-f sho nr other transatic event, the Medical Francis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1635 Ceddox Street U.S.A. 21226 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Armed Forces? 1 X Yes White If Yes, Give Year or Dates: Yes 2 X No specify: Specify: 3 Widowed 4 Divorced <u>≨</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Installer Garage Doors 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gary Anderson Charlotte Brown Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٥ 1635 Ceddox Street Baltimore, Maryland 21226 Charlotte Keirle / Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 04/26/2011 Baltimore, Maryland 4 Donation 5 Other Specify. 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 21 Signature of Funeral Service Licenses Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Carisoprodol Intoxication Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): ner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is

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Medical

State Registrar

30. Name and addres of person who completed cause of death (Item 23a)

Assistant Medical Examiner Registrar's Sign

Pamela E. Southall, MD

31. Date filed (Month

d.					
X UNPENDED X	AMENDED 29d per verb. 23a,27,28a-f	g914 4-28-11 vi per me g915 5-9	-11 vt		
IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery	
23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3 Ectopic pregr	nancy	Month Day	Year
1 Yes 2 No 9 Unknown	9 Unknown	iner (Specify)			
Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cau	se of death?
-			1 Yes	2 No 3 Probably	1 Unknown
			24a. Was an autopsy performe	24b. Were autopsy fi prior to complete death? No 1 Yes	
25. Was case referred to medical		26.Place of Death (Checi	k only one)		
	ospital: 1 Inpatient 2 ER/Outpatier	nt 3 DOA Other Nurs	ing Home 5 Re	esidence 6 🗸 Other: Scene	,
27. Manner of Death	28a. Date of Injury 28b. Time of	Injury 28c. Injury at Work?	28d. Describe hov	w injury occurred	
1 Natural 5 Dending	(Month, Day, Year)	1 Yes 2 🗶 No			
Pending	fd 4-19-11 fd 11:	:30an '- '83 ZE '8	unknown		
2 Accident Investigation 3 Suicide 6 X Could not be determined.	28e. Place of Injury - At home, farm, stre		or Town, Stat	eet and Number or Rural Rou e) 96 Weldon R	ite Number, City \mathbf{d} .
4 Homicide	(Specify) residence	ce	Curtis B	ay, Mu.	
29a. Certifier 1 Certifying Physicial Check only	an: To the best of my knowledge, death occu	urred at the time, date and place, ar	nd due to the cause(s	s) and manner as stated.	e(s)
one) 2 Medical Examiner	and manner stated.	adon, in my opinion, acadi occurred			` '
29b. Signature and title of certifier	and maintai states.	29c. License number	2	29d. Date signed (Month, Da	y, Year)

OCME

111 Penn Street, Baltimore, MD 21201

4-20-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician/ 04 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** <u> Anne Arundel</u> 423 Shady Lane Pasadena 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Sept 3, Year 24 Days Min 1 XM 2 □ F Months Hours Maryland 217-18-6061 Director 86 Yrs Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Tes 2 No <u> Anne Arundel</u> Pasadena MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral USA 21122 423 Shady Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. white If Yes, Give 3 Widowed 4 Divorced 43-46 Completed Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) fire fighter/ambulance driver public service 10 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Homer Johnson Bullington Sr Elsie Mae Frey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 423 Shady Lane Pasadena, MD Leota Bullington/spouse Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) permit. Page Department o Important: If any injury or Signatur - If Euneral S. rvice Licensee Ronal d S. Wade State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 7 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe.

Immediate Cause (Final Approximate Interval Betwee Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

To the Funeral Director: After this certificate has been signed by the attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day 2 🗌 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 2 🗌 No 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes → No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🗆 No injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number

State Registrar Name and address of person who

DEVENSE

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State o	of Mar	yland	-	artmer <i>rtificat</i>				Mental Hy		00		1.0	
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Medio Examin		4a. Facility Name (if not institu Heritage Cer		street and nurr	nber)				Town, or dalk	Location	of Death		-	4c. County	of Deat		
Funeral Director		5. Social Security Number 219–30–6530	6. Se:	х Z M 2 \square F	7. Age (h	n yrs. la. 78	st birthday) Yrs.	If Unde Months	r 1 Year Days	If Unde Hours	Min.	8. Date of Bird (Month, Pa 2/16/1	h y Yea	3)		hplace (Star Intry) huania	te or Foreign
		Usual Residence of Decedent										127.107.					
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 ☐ Never Married 2 ☐ 3 🔀 Widowed 4 ☐ Divo	ced	1 ☐ Yes If Yes, Giv Year or Da	2 X No)	1	1 🗆 Yes								ite	
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Page nent of		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			State		metery, cre dowri				4/29	9/2011	El	kridg	e, N	Maryla	nd
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	by Physician/Medica	Part II. Other significant con	ditions co	ntributing to d	eath but	not resu	ulting in the	underlying	cause giv	en in Par	t I.	23e. Did to	obacc	o use cont	ribute to	the cause of	of death2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BRYAN Month Year VIRGIE LORRAINE 11:37 M APR 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOWARD COUNTY GENERAL HOSPITA COLUMBIA HOWARD COUNTY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 (Month, Day, Yea Days Hours 81 Virginia **Director** 228-32-5859 1/930 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No MD Columbia Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 780 Cradlerock Way 21045 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black White etc ō 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: White "natural", 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I n and Mental Hygiene. 7 is marked other than "r Washington & Elementary/Seconday (0-12) College (1-4 or 5+) 10 Clerk Lee Hotel injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Rage 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic of Alphie Omega Weaver Florence Exline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Samabataro/Daughter 1529 Maydale Dr., Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Departion 5 ☐ Other (Specify) Grant United other place) 04-27-2011 Methodist Lerty, Virginia Welch Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 17546 Kings Highway, Montross, VA 22520 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ PNEUMONIA ASPIRATION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last OLON CANCER sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical HYPERTENSION PULMONARY Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month Year the detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ should be Hospital or Attending Physician: The law requires ANEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ANXIETY 24a. Was an page 2 s has autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No funeral director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prijactioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Mychiley 00064760 APR, 23, 2011

Registrar
DHMH 17 Rev 7/2009

State

MYTHILY

31. Date filed (Month, Day, Year)

10710 CHARTER DRIVE SUITE # 310, COLUMBIA.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary R. Barr April Physician/ 2011 9:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Dundalk Genesis Heritage Meridian Ctr. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day Year) ept. 28,1917 1 M 2 X Months Days Hours Maryland Director 93 <u> 218-14**-**1089</u> 28a-f show 10b. County 10d. Inside City Limits Director 10a. State 10c. City, Town or Location 1 Yes 2X No Edgemere MD Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? United States 21222 7711 Bayfront Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Completed 3 ₩ Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Moose Lodge <u>Barma</u>id 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Blimline Edward Roedder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

75.22 Fort Ave. Et Howard, Maryland 21052 19a. Informant's Name/Relationship (Type, Print) Ft. Howard, Maryland 7523 Fort Ave. Mr. Robert Buyny (Son) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 🔯 Burial 2 🗌 Cremation 3 🗍 Removal from State Baltimore National Cem. 4/29/2011 Baltimore, Maryland Nonation 5 Other (Specify) 21. Signa ure o Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line SCLEROTIC CARDIO-VA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregn 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con - ute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the lirector, page 2 s autopsy perform 25. Was case referred to medical 26. Place of Death (Pheck only one) Certificate: To Be examiner? Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Mann of Death nours after death.

neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natura 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on and title of certific M.D cause of Leath Men 200 (Type, Fright 0 - A

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

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32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:00 PM HENRY BETZ **Physician** APRIL 201 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 23,1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F Maryland 84 Director 220-18-5893 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Dunda1k MD Baltimore 1 and 2 should be filed within 72 hours after death with the Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a. 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 21222 5 Midway Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □xYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: à 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Eastern Stainless Elementary/Secondary (0-12) College (1-4 or 5+) Steel Corp. 12 Years Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lessie Bullock Henry Betz ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 21222 5 Midway Avenue Betty M. Betz (Wife) of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any Injury or oth 1 Burial 2 Cremation 3 Removal from State 4/23/2011 Middle River, MD 4 □ Donation 5 🗙 Other (Specify) Entombmt. Holly Hill Mem. Gdns: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRYHTHMIA MINUTES Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are the control of the con Examiner to (or as a consequence of) burial-transit CHRONIC ASPIRATION resulting in death) Last Due to (or as a consequence of) attending physician DEMENTIA Physician/Medical the use as 1 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Day Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 TYes 2 No 3 Probabiy 4 Unknown CUMUNANY ANTENY 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 🗌 No 1 TYes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Inpatient ၉ within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Box 68760. P.O. Division of Vital Records,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Attending Physician: b To the Hospital

State Registrar

Medical

29a. Certifier

(check only



and manner stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

32. Register's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month D M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner A Himore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. 1 🗆 M 2 💢 F Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anoe. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Yes 2 No altimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? USA 21202 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 🗆 Yes 2 📈 Specify Black 3 Widowed 4 Divorced Year or Dates 24,2011 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary (Seconday (0-12) College (1-4 or 5+) Home make Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Rosedale Sor permit. Page 1 and 2 s Department of Health 20b. Place of Disposition (Name of cemetery, crematory or other place, Loudon Park Cem 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, MI -29-2011 4 Donation 5 Other (Specify) 21. Signature of Fune a ervice Lie ee 22. Name and Address of Facility E. North Are March 21202 Itimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b funeral director, page 2 autopsy perform 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Manner of Death Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 2 🗌 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and ause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:57 A M Brown 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore A 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Country) **Director** marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Completed by Funeral Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Cedonia 83 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) life, DO NOT use retired) Cpllege (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ Brown, Lorothu Brown James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ced onia lenda Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Kandallstown 29-2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen March 21202 ltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 6876 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown Part II. Othe significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been signated by 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to m 26. Place of Death (Check only one) examiner? ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year April 25, 3:15 P 2011 Physician/ Mavis Iona Bascom Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign Country) South Juyana, America If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Months Hours Min. Feb 1, 1923 **Funeral** Days 88 1 M 2 XXF Guyana, 217 94 0578 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State J. Hygiene. other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 1 Yes 2XXNo Completed by Funeral Director Oxon Hill Prince George MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 20745 5501 Galloway Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinations. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 Never Married 2 Married 2**XX** No **Black** Specify: 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 3 X Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) Own Home College (1-4 or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Anna Pyle မှ Alfred Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5501 Galloway Drive, Oxon Hill, MD 20745 19a. Informant's Name/Relationship (Type, Print) Loretta Bascom Ross (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State April 30, 2011 Clinton, MD Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Service Licensee Ferry Road, Clinton, MD 20735 70015 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pheumania Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): **Examiner** Sequentially list conditions Lunto (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day in the past 12 months? Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Hospital or Attending Physician: The law requires Completed ficate has been siç r, page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 🗌 No 1 🗌 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Tes မ 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: work?
1 Yes 2 No 5 Pending Natural M Investigation hin 24 hours after death. the Funeral Director: A Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined completed filled in by 4 Homicide Medical 29a. Certifier (Check To the within 2 29d. Date signed (Month, Day, Year) only one) 29c. License number 29b. Signature and title of certific 101 26-2011 D65729 30. Name and address steerson who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7: SS 111 2011 -nri Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** beth Bal 120 ent more WSING If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs Funeral 1 □ M 2 🗶 F Months Days Jan 3Day 930 219-28-4461 81 Washington D.C. Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Code 21227 Funeral 3320 Benson Avenue ıral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White ☐ Yes 2 🛣 No "natural", 3 Nidowed 4 Divorced Year or Dates and 2 should be filed within 72 houn Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Ethe1 Byrd Richard Vosler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gatton/ Daughter 2758 Yarnall Rd. Halethorpe Md. 21227 Department of Health Important: If item 27 any injury or other the Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Page 1 4/26/2011 Balto. Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee Ritchie Hwy. Baltimore Md. 21225 4001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ 05t disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death g Unknown should be detached g Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy 1 🗌 Yes 2 🗆 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 일 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my animals. It will be a second or investigation in my animals. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The decident Examiner: On the basis of examination and the standard and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2011 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 3320 enson State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Darrell Kipling Barber 1- For State Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 19, 2011 2150 hrs **Medical Examiner** Darrel1 Kipling Barber 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Fort Washington Prince George's 3429 Lumar Drive 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** 6. Sex Months Days Hours Min. Director Country) Illinois 1 M 2 F 04/18/1959 217-74-0739 52 Usual Residence of Deceden 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County 1 X Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Fort Washington Prince Georges Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 3429 Lumar Drive USA Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X No 1 Yes 2 No specify: Give Year 3 Widowed 4 Divorced Specify: **Black** ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed)

Physician /Medical Examiner

Completed

Be

ဥ

Elementary/Secondary (0-12)

17, Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Donald Barber

College (1-4 or 5+)

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physic; completely litled in by the funeral director, page 2 should be detached for uses as the built.

	June Jones/Mother	1202 Parker Ave. Hya	attsville <u>,</u> MD 20782								
111	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or 1	Town, State							
	1 X Burial 2 Cremation 3 Removal from State	crematory or other place)									
	4 Donation 5 Other Specify:	Ft. Lincoln Cemetery 04/	29/2011 <u>Brentwood</u>	, MD							
	21. Signature of Funeral Service Licensee	22. Name and Address of Facility E+	. Lincoln Funeral Ho	ome Inc							
W	Joya Montgomen Cheatha										
	23a, Part I Inter the disease r complications that caused the		Road Brentwood, MD	20722 Approximate Interval							
	failure. List only one cause on each line.	e death. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or neart	Between Onset and							
	Immediate Cause (Final disease a. Intracerebi	cal hemorrhage associated	with cocaine use	Death							
	or condition resulting in death) Due to (or as a consequ										
	. But to (or us a corrisory)	(a) (a) (b) (a) (b) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c		· .							
L	Sequentially list conditions,										
9	if any, leading to immediate Due to (or as a consequing cause. Enter Underlying Cause	ence or):									
Examiner	(Disease or injury that initiated C			W							
Xa	events resulting in death) Last Due to (or as a consequ	ence or):	A3	Y							
	d										
Physician/Medical	□ UNPENDED □ AMENDED23a,2	7,per me,g915 5-24-11 sm									
ě	IF FEMALE: 23c. If yes, outcome	of pregnancy	23d. Date of delivery								
'n	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year										
ä	past 12 months? 4 Pregnant at time of death 5 Other (Specify)										
S	1 Yes 2 No 9 Unknown 9 Unknown	Officer (Opecary)									
٤	Part II. Other significant conditions contributing to death b	ut not see this is the underlying egues siven in Port I	23e. Did tobacco use contribute to the	he cause of death?							
Š	Part II. Other significant conditions contributing to death b	ut not resulting in the underlying cause given in Fart i.									
о О			1 Yes 2 No 3 Proba	ably 4 V Unknown							
ş				opsy findings available							
ă			autopsy prior to co	ompletion of cause of							
Completed			1 ✓ Yes 2 No 1 ✓ Yes	s 2 No							
	25. Was case referred to medical	26.Place of Death (Check									
8	examiner? Hospital:		ing Home 5 Residence 6 Other:	Canno							
2	1 ✓ Yes 2 No			Scene							
اے	27. Manner of Death 28a. Date of Injury (Month, Day, Year	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred								
ᅙ	1 Natural 5 Pending	1 Yes 2 No									
g	2 Accident Investigation	y - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rur	al Route Number City							
١	3 Suicide 6 Could not be	y - Actionie, iarm, street, ractory, onice building, etc.	or Town, State)	ar route Number, Oily							
edical Certification	4 Homicide determined (Specify)			- 1							
=	29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, death occurred at the time, date and place, an	d due to the cause(s) and manner as state	d.							
3		ation and/or investigation, in my opinion, death occurred									
77	and manner stated.	•									

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

during most of working life. DO NOT use retired)

Product Support Engineer

18.Mother's Name (First, Middle, Maiden Surname)

June D. Harris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Private Industry

20782

29d. Date signed (Month, Day, Year)

April 20, 2011

State Registrar

Marsic 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29b. Signature and title of certifier

Melissa Brassell, MD

do

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Phylicia Simone Barnes State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Phylicia Simone Barnes 0738 hrs **Medical Examiner** April 20, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Darlington Harford Route 1 at Conowingo Damn 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) Min 254-89-2899 Months Davs Hours 01/12/1994 Director 17 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location and a NC Union Monroe 1 Yes 2 XNo 28a-f show 1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trunent of Health and Mennal Hygene.
Tauti. If item 27 is marked other than "natural", or items 23a or 28a-f she yor other traumantic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 28110 205 Clark Rd. 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XX Never Married 2 Married Yes Black 1 Yes 2XX No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student Education 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Janice M. Sallis Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 639 Garden Walk Blvd., Apt 605, College Park, 30349
e of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Janice M. Sallis / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 XX Cremation 3 Removal from State The Crematorium Austell, GA 04/27/2011 4 Donation 5 Other Specify Parl Representation Service, Bailey Funeral Home and Cremation Service, 4023 Annapolis Rd., Halethorpe, MD 21227 21. Signature of Funeral Service License Mark E. Bailey Mal M01452 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Madical Asphyxia Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a,27,28a-f per me g915 5-2-11 vt X UNPENDED attending physician or use as the burial AMENDED Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: 1 Natural nours after death. 5 Pending 1 Yes 2 X No subject was asphyxiated fd 4-20-11 7:38am Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide 6 Could not be or Town, State) 2326 Glen Cove Rd. Darlington, Md. determined (Specify) found in water Homicide 29a. Certifier (Check only)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I To the 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) April 21, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 15, Day 2011 **Physician** 6:30 PM M Evelyn Cobbs /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Baltimore 30 Sorgen Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 13, 1932 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 78 Tennessee **Director** 295-26-7485 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f show 1 ☐Yes 2 ☐ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Sorgen Court 21220 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗓 No white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumest. Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd Hurst Edna Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christie Clements/granddaughter 7 Catapult Court Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services State Anatomy Board 655 W. Baltimore Street 200 21201 Baltimore, MD entur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the art failure. List only one cause on each ine. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) cars the burial-transit and Due to (or as a conse physician IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 🗷 No page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed nours after death.

neral Director: After this y filled in by the funeral di within 24 hours a To the Funerai

> State Registrar

4 Homicide

29b. Signature and title of certifie

29a. Certifier

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

bwland

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

32. Registrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

32. Relistrar's Signature

Seren

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year PM Elva M. Cook 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square Raltimore Franklin osedale Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, 1 □ M 2**X** F Months Days Hours Min Maryland 90 217-58-6975 Director Nov. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Sparrows Point 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9100 North Point Road 21219 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked out. þ 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 24 ☐ No Specify: White 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Hardware Store Owner Hardware Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Dawson Margaret Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7806 Denton Ave. 21219 Vera C. Hinkleman (Daughter) Sparrows Pt., Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Moreland Mem. Park Cem. 4/27/2011 1 Burial 2 Cremation 3 Removal from State Other (Specify) 4 Donation Baltimore, MD eral Service Name and Address of Facility uda-Ruck Funeral Home of Dundalk, Inc. Si noture 7922 Wise Ave. Dundalk, Maryland o not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Priysician/ Die to (or as a consequence of): disease or condition Medical resulting in death) Examiner D Ves Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed 2 No Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 EResidence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No 2 Accident Investigation after death Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one) 29b. Signature and title of cert April 21,2011 462867 D.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frankin Square Drive, Baltimore, MD 21237

31. Date filed (Month, Day, Year)

32. Registrar's Signature State APR 28 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Antonios Chalcoussis 2011 6:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Center Baltimore Co. Towson **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ May 13, 1917 Greece **Director** 197-12-3741 93 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 XNo MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 23 Liberty Parkway United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 1 Never Married 2 Married ģ ☐ Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3X Widowed 4 ☐ Divorced Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Poplar Inn Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Demetrois Chalcoussis Sevasmia Apessos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2555 Liberty Parkway Dundalk, MD Michael Adams (Son-In-Law) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4/29/2011 Baltimore, Maryland Donation 5 Other (Specify) 21. Six at Inc. of Funeral Service License ^{22. Name and Address of Facility}
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final colon Physician/ met CHNCER 4 ear Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Director: After this certificate has autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and title of certifier 29c. License number 025205 and address of person who npleted cause of death (Item 23a) (Type, Print) 6701 31. Date filed (Month, Day, Year) State 8 201 2 Registrar

DHMH 17 Rev 7/2009

			Please	Type or Print in Black Indelible Ink. Ensure All Copies Are Legit	ole.
			For	State of Maryland / Department of Health and Mental Hygiene	1 13553
			State Registrar	Certificate of Death Reg. No.	1 10000
	Physicia	ın/	1. Decedent's Name (First, Middle, Las		3. Time of Death
-	Medic Examin		4a. Facility Name (if not institution, give		
	<i>j</i>		Belvodere Assi	sted Living Home Battimore	
	Funeral Director		5. Social Security Number 6. Se	7. Age (In y/s. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth W M 2 F Yrs. Months Days Hours Min. (North Day Year)	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent		FA
	yland -f sho ed at	ctor	10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	ne Mar r 28a notifi	Dire	10e. Street and Number	A Daltamore 10f. Zip Code 10g. Citizen of Wh	1 Yes 2 No
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At of Health and Mental Hygiene is to file file in 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	1919 & Bo	1 vadora Ava 21239	SA
	leath items ier mi	Fun	11. Marital Status		- American Indian,
36	after of	d by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No No No No No No No No No N	White, etc.
8	hours natura ical E	lete	15. Decedent's Ed		iness Industry
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2	led within Hygiene. other tha ent, the N	Be C	17. Father's Name (First, Middle, Last)		more Sun
A. Maryland	should be file and Mental F is marked o raumatic eve	To E	Prince of Last	Crist Rhoda M. To	sten
ary ary	2 should th and Me 27 is mar traumati		19a. Informant's Name/Relationship (Ty		
	1 and 2 s of Health item 27 i		Linda Brick	Kington 14645 Marbie Hall Road Bay-	to Mo
	Page 1 ar nent of H ant: If iter ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	City or Town, State
/////saltimore.	Page and		4 Donation 5 Other (Specification)	W Garrison Forest 4/12/11 / Owings	Mills, Mo
28/1 ■ Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licens	22. Name and Address of Facility Russ Funcion Hon	MO 21216
8			23a. Part 1. Enter the disease comp	plications that caused the death. Do not enter the mode of dying, such as carrilac or respiratory arrest, ne cause on each line.	Approximate Interval Between
18	Physician/		Immediate Cause (Final disease or condition	CARCIND MA OF COUN	opset and Death
1	Medical Examiner		resulting in death)	Due to (or as a con equence of):	
AR.	Same and	ier	Sequentially list conditions,	b. — Dus to for as a sunsequence of:	20
N.	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	•	
) \	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of):	
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Box 68760	ertifica ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 23d Date	of delivery
ŏ	eath c atten	iciar	in the past 12 months?	1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Mont	
	the d by the tachec	hys	9 Unknown	9 ☐ Unknown	
15t	ss that igned be de	Completed by Physician/Medical	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	ute to the cause of death?
C. R.	require	eted	DM		
	e law r e has t ge 2 s	ldu	11/	performed? de	ere autopsy findings available for to completion of cause of ath?
. 00	in: The	o C C	25. Was case referred to local	1 ☐ Yes 2☐ No 1 26. Place of Death (Check only one)	Yes 2 No
S /	nysicié lis cer direct	To Be	examiner? 1 ☐ Yes → T☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other	(Specify)
2/2	ing Pt	ate:	27. Manner Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28d. Describe how injury occurred work?	
A R. Sion	death death stor: A y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1	or Rural Route Number
ChAR Division	al or A s after I Direct d in by	Cer	4 Homicide determined	building, etc. (Specify) City or Town, State)	or riaral ribato riarribos,
	lospita Hourr unera ed fille	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	sician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to	as stated.
	the H thin 24 the F	Me	only one) 3 Certifying Nurs	se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mani	ner as stated.
	6 ₩ 6 8		29b. Signature and title of certifier	29c. License number 29d. Date slighed (24/3)	worth, pay, rear)
	1		30. Name and address of person who	rempleted cause of death (Item; 23a) (Type Print)	
_			JOHN W. PO	WING 4100N CHANRES ST. MAITO, MX	212/8
	Stat	te	31. Date filed (Month, Day, Year)	S2. Registry's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Carter Stanley 24, 2011 6:19 P April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Co. 186 Campus Green Drive Arnold 6. Sex 1 M 2 D F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min Yrs **Director** Ohio 219-03-4519 01/11/1917 Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Tes 2 X No MD Anne Arundel Arno1d ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21012 186 Campus Green Drive U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. by 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify "natural", Specify: White 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Westinghouse Wiring & Assembler Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Merithew Carter Florence Ε. Nathaniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, MD 21012 522 Norton Lane Mr. Calvin Carter / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Warrial 2 Cremation 3 Removal from State Glen Haven Mem. Park: 04/30/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease Or impury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the all 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 🗗 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tyes Other: 2 PNO 475/5/4 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) -0 0 who completed cause of death (Item 23a) (Type, Print) 11007 31. Date filed (Month, Day, Year) trar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month HAR COR BIN 12:00 AM 2011 APRIL Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 130 M SECOURS HOSPILAL BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Days Min Director 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No mor ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. ife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked o ည 19a. Informat's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 22 Name and Address of Facility (21. Signat uneral Service License e o neval Home, anyi 24 Part 1, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between SEASE Immediate Cause (Final CARDIOVASCULAR Physician/ ERJENSIVE disease or condition Medical resulting in death) e lo (or as a consequence of) Examiner END STAGE RENAL Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami SEPTICEMIA that the death certificate be executed Due to (or as a consequence of) resulting in death) Last IMMUNODEFICIENCY VIRUS Physician/Medical the. attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregont 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 mg 1 Yes 2 1 Month Day Year Pregnant at time of death Unknown No signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) 1 Tyes Other: 2 No Impatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00030355 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOURS 0 J.A. 31. Date filed (Mont) State 8 20

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

11-03047 William Coleman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	Reg	. No.	
Physiciar Medical Examin	n/	1. Decedentis Name (First, Middle, Last) Cole man	2. Date of Death Month I April 21, 20	Day Year 11	3. Time of Death 1710 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2206 BDDne Street Baltimbre		4c. County of Dea	th
Funeral Director	(5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Althoration Months Days Hours Min.	8. Date of 8irth	(MM/DD/YYYY) 9. 8 Fore	
daryland 28a-f show any 1 at once,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore	Lido	OW	10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	2602 Bonne. Street 21218	109	g. Citizen of What Co	A.
er death wi	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 ViDivorced of Figure 1 Status 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:		14. Race - Ame White, etc.	lack
036 tthin 72 hours and the control of the control o	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)		16b. Kind of Business	oled
21215-0036 uld be filed within 7 Mental Hygiene cevent, the Medica	0	17. Father's Name (First, Middle, Last) 18. Mother's Name (Lee Coleman Euri	ce u	Joods	
MD 21 12 should 12 should th and Me 27 is ma	L	19a. Informant's Name/Relationship (Type, Print) (Mother) 19b. Mailing Address (Street and Number or Re Mrs. Eunice (Deman 1300 & Lanvale S	+. Ap+	#330B	atto, MD
Baltimore, MD 2 semit. Pages 1 and 2 shou Department of Health and N mportant: If Item 27 is enjury or other traumant		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Cremation 2 Cremation 3 Removal from State	Date 7	20c. Location - City of Durdal	K MD
	-	21. Sign trues of Funeral Service Licensee 22. Name and Address of Faulty 23. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	Ave B	alto , N	P A: 1916 Approximate Interval
Physician Medical Examiner	1	fajlure. Listonty one cause on each line. Immediate Cause (Final disease a. Methadone Intoxication and Cocaine		n, SHOCK, OF FREAR	Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):			
	틹	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	. <u>-</u>		-
execut	Medical E	d. ☐ AMENDED 23a,27,28a-f per me g915 5-9-1	1 vt		
Box 68760, c death certificate be extending physician defor use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ncy	23d. Date of delive Month	ny Day Year
i, P.O. B ires that the d signed by the	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death? bbably 4 Unknown
Division of Vital Records, P.O. Box 68. the Hospital or Attending Physician: The law requires that the death certifithin 24 hours af er death. The Funeral Director: After this certificate has been signed by the attending the Funeral Director: After this certificate has been signed by the attending the Funeral Director, page 2 should be detached for use as	Completed		24a. Was an autopsy perform	prior to ned? death?	
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical examiner? [Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing		esidence 6 🗸 Oth	0
of Vi	유	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		w injury occurred	er. Scene
On C cending sath.	[]	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation fd 4-21-11 fd 5:03pm 1 Yes 2 X No	unknown		
Division of pital or Attending Phous af er death over all bectors. After tilled in by the funeral	Certification:		28f. Location (Str or Town, Sta Baltimo	te) 2206 Box	Rural Route Number, City
To the Hos within 24 hc To the Fun completely	ल	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated			
	ž	29b. Signeture and title of certifier 29c. License number O.C.M.E.		29d. Date signed (M April 22, 2011	onth, Day, Year)
0	1	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, M	1D 21223		
Sta Registr		31. Date filed (Month, Day, Year) APR 28 2011			

DHMH 17 Rev 1/2001 OCME 2006

11-03166	
Jeanne Ann Curry	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Cen	tificate of	Death			Re	eg. No.		
Physicia Medical Exami	an/	Decedent's Name (First, Middle Jeanne Ann							Date of Deat Month April 26, 2	Day Yea	ır	3. Time of Death 0801 hrs
3		4a. Facility Name (if not instituted Upper Chesapeake M		nber)	4	b. City, Town, o Bel Air	or Location	of Death		4c. County of Harford	of Death	
Funeral Director		5. Social Security Number 532–74–3231	6. Sex 7	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Ye			8. Date of Birl 12/29/	th(MM/DD/YYYY 1974	Foreign	
Maryland 28a-f show any d at once.	ctor	Usual Residence of Decedent 10a. State			Fown or Location	n 10f. Zip Code			I10	Og. Citizen of Wh	nat Coun	10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f sho pe notified at once	Il Director	4237 Zalesky				80326				USA		
ırs after death tural", or iten	d by Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe	Armed For 1 X Yes Vorced If Yes, Give Year or Dates:	² □ № 1997–199	If Ye 99 1 16a. Decedent'	Decedent of Hs, specify Cuba Yes 2 X N s Usual Occup st of working life	an, Mexican o specify. ation (Give	n, Puerto Ri	can, etc.)	Specify:	o, etc. Whi	
5-0036 led within 72 hor Hygiene. to the ritan "nai	Completed	Elementary/Secondary (0-12)	College (1-4	4 or 5+)	_	e Thera		use retired	1)	Self-e	mplo	yed
21215-0036 onld be filed within 7 Mental Hygiene. I marked other than it event, the Medic	Be	17. Father's Name (First, Middle Douglas Lee C	turry	•				•	irst, Middle, M n Junc	Maiden Surname)		
MD 21 nd 2 should ulth and Me m 27 is ma aumatic ex	2	19a. Informant's Name/Relations Pamela A. Finl		r						ber, City or Town		Zip Code)
imore, Pages 1 ar nent of Her ant: If ite		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	- Ct-to Cr	ace of Dispositematory or other Arundel	cremat	cory	04/28	3/2011	20c. Location - Odento	n, M	ID
		23a. Part I. Enter the disease, or		M01452								vice, PA 227
Physicían /Medical. Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <u>Methado</u>	ne and	0xycodo				espiratory arre	sst, shook, of field	,	Between Onset and Death
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a c									
ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
760, icate be executed physician and the burial • transit	edical	X UNPENDED	d AMENDED 2	3a,pt.1	1,27,28	8a-f,g9	15 5-	12-11	sm			
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	23c. If yes, ou 1 Live birt 4 Pregnar	itcome of pregna th nt at time of deal	2 Feta			c pregnanc		23d. Date of Month	-	ay Year
ires that the designed by the detached is	2	Part II. Other significant condit Hypertensive			sulting in the un	derlying cause	given in Pa	art I.	23e. Did to		_	he cause of death?
cords	Completed	nypercensive	. Heart Dis	case					24a. Was a autops perform	sy p m <u>ed</u> ? d		opsy findings available ompletion of cause of
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medica examiner?	11 11 1	patient 2 🗸 E	R/Outpatient			(Check onl		Residence 6	Other	
on of V nding Phy th. r: After th	ion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pence	28a. Date of (Month, D	f Injury 2 Day, Year)	28b. Time of Inj	ury 28c. Inj	ury at Work	⟨? 28	d. Describe h	ow injury occurre		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 X Couldete	d not be	of Injury - At hon Residen			building, et	- 1	or Town, St		Banti	ral Route Number, City
To the Hospital within 24 hours: To the Funeral completely filled	ल	Torrota only	hysician: To the best of miner: On the basis of and manner stai	examination and								
F 3 F 3	We	29b. Signature and title of certific					.M.E.			29d. Date signe April 27, 20		th, Day, Year)
		30. Name and address of person Ling Li, MD Assista	who completed cause nt Medical Exami			Street, Ba	Itimore, I	MD 2122	23			
Sta Regist		31. Date filed (Month, Day, Year)	32 Regi	istrar's Signature	back							
DHMH 17 Rev 1/20	01	APRECE	111	70.	ORIGINAL				OC NE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 11:30^A ^M 2011 26 Paul E. Carter April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate Chesapeake Hospice House If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Months Director 67 213-44-5356 1944 Washington, DC 18 April Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No Prince George's Lanham Md 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20706 9109 Kinzer Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Elevator Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bertha Morgan Richard Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9109 Kinzer St. Lanham, Md 20706 Shelby Carter / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4/30/2011 Brentwood, Md Ft. Lincoln Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee.

22. Name and Address of Facility Fort Lincoln 3401 Bladensburg Rd Brentwo

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Fort Lincoln Funeral Home Brentwood, Md Approximate Interval Between Onset and Death Privsician METESTETIC Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy
performed?

Yes 2 🔀 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To within 24 hours after deau..

To the Funeral Director. After this commisted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-28-11 aus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) iov Greenbelt MD 266UM J = 1525 WELTZ

DHMH 17 Rev 7/2009

State Registrar

			For State	Plea	ase Type amend Sta	e or Pr i I item ate of M	i nt in 23a Iarylar					ure A I vt and M	III Copie Mental Hy	s Ar gien	e Leg	ible.	13559)
	Dhusisis	/	Registrar 1. Decedent's Name		e, Last)				πιτιςε	te of E)eath		2. Date of De			_	3. Time of Death	
5.	Physicia Medic	cal	Jos 4a. Facility Name (if	eph	Rob		C	herry					April :	T			0.00 u	M
	Examir	ier		rt Hom		na number)				ty, Town, or thicu			3	4c. County of Death Anne Arunde1				
	Funeral Director		5. Social Security Nu 220-12-		6. Sex 1 🙀 M 2		ge (In <i>yrs. I</i>	last birthday) Yrs.		der 1 Year	If Under Hours		8. Date of Bir (Month, Da	th Year)		g. Birt	hplace (State or Foreig	gn
	3	_	Usual Residence of 10a. State										верс.	20,	1920	Mai		
	Maryland 28a-f show otified at	Director	MD	10b. County Anne	Arund	el		ty, Town or Lo thicum									10d. Inside City Limit 1 ☐ Yes 2√☐ I	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 23, Day 2011 Year 8:10 p Physician/ Clutz Wilmer James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min Augnth, 29 Year] 1960 Mary Pand 1X M 2 - F 50 Vre Director 216-82-6528 Usual Residence of Decede 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 27230 USA 723 Dover St. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2x No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Display Interior Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Geraldine В. Snyder G. Clutz Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 Dover St., Baltimore, MD 21230 Walter J. Washel III (Per. Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or Loudon Park Cemetery 4/28/11 |Baltimore, Maryland 4 ☐ Donation 5 🕱 Other (Specify) Entombment 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lic. 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate

Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 1 Yes BB 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital pice 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner To the b 29b. Signature and 25205 wo ed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? 1 | 356 amend State Of Marylane? Department of Health and Mental Hygiene

			- For State	-	Certi	ficate of	Death			R	eg. No.		
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ledical Exa	min		WILLIAM CANN							April 22, 2			
			4a. Facility Name (if not institution,			4	b. City, Town, o	or Location o	of Death		4c. C	ounty of Deatl	n
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page	Ca	Charter Ceruiving Pily	sician: To the best of my iner:On the basis of exam	, knowledge nination and	s, death occur d/or investigat	ied at the time, ion, in my opini	on, death oc	curred at	the time, date	and place	e, and due to t	he cause(s)
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	1	2	Zab. Signature and title or certifier								1	23, 2011	
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		-	30. Name and address of person w						D 400		4000		
00.			Name and address of person w Donna M. Vincenti, MD Day, Year)		al Exami	iner 900	W. Baltimo	re Street,	Baltim	ore, MD 2	1223		17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 25, Physician/ 2011 1:50 A M **JEFFREY** IRL COHEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON GILCHRIST HOSPICE CARE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Months 1 XM 2 F Month Day, Year) 49 MD61 **Director** 213-48-9080 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Tes 2X No OWINGS MILLS MD BALTIMORE 10f. Zip Code 10a. Citizen of What Country? 0 10e. Street and Number Funeral or items 23a USA 3902 THOROUGHBRED LANE 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: WHITE "natural", 3 Widowed 4 Divorced or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) f Health and Mental Hygiene. College (1-4 or 5+)
5+ Elementary/Seconday (0-12) HUMAN RESOURCES MANAGEMENT HEALTHCARE Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ COHEN FANNIE GILBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3902 THOROUGHBRED LANE, OWINGS MILLS, MD ROCHELLE COHEN/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State 04/28/2011 LEWES, DE SEASIDE JEWISH CEM. 4 Donation 5 Other (Specify) f Funeral Service Life 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock. or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause or nterval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy perform 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 KOther (Specify) Housice 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DCA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No after death Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. Suite 4105, Baltimore, MD

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 07:00 PM **Physician** April 19 2011 Jerettera Davis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital of Baltimore Baltimore Citu 8. Date of Birth (Month, Day,
June 7, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) Funeral Hours 1 □ M 2 X F 55 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1♥ Yes 2 No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21223 1901 W. Baltimore Street unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? atient known as Jevettera Davis Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married black Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed unit 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 2401 W. Belvedere Avenue Baltimore, MD Sinai Hospital 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o oonce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 【 Other (Specify) in state State and temparte my a Board 655 W. Baltimore Street 21. Sign tura of Funeral Service Licenses Director Baltimore, MD 21201 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 days Sepsis Physician /Medical Due to or as a consequence of): 10 days Examiner Metabolic acidosu Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by End-stage renal disease, End-stage liver disease, recvient ascite 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? secondary to circhosis of liver and Hepatitis C 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manper of Death 28a 28b. Time of 28c. Injury at 5 Pending investigation 1 Natural 2 □ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES_000 April 19, 2011 MO, PLD

State Registrar

DHMH 17 Rev 1/2001

Singi Hospital of Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, PhD

P. Benavioles

David

31. Date filed (Month, Day, Year) APR 2 8 2011 11-03059

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onis Love Dui	nn	State 1- For State Registrar	e of Maryland		artment of rtificate of		and I	Mental		eg. No.	201	1 13564
Physic		Decedent's Name (First, Middle,La	ast)						2. Date of Dea Month	th Day	Year	3. Time of Death
Medical Exam	niner	Lonis Love Dunn							April 22, 2	2011		0349 hrs
		4a. Facility Name (if not institution, g Upper Chesapeake Med		er)	4	b. City, Town Bel Air	n, or L oc	cation of D	eath	4c. Cou Harfo	inty of Deat ord	th
Funera		Social Security Number 6.		Age (In yrs. I	ast birthday)	If Under 1	Year Days	f Under 24 Hours	Min.		Fore	irthplace (State or ign Virginia ountry)
Directo	1	220 24 3330	M 2. X F		82 Yrs.				Sept 1	.5 , 19:	28 ^c	ountry)
any		Usual Residence of Decedent 10a, State 10b. County		10c. City	, Town or Location	on						10d. Inside City Limits
		Maryland Harfo	rd.		Fdo	ewood						1 Yes 2 No
larylar 38a-f s	cto	10e. Street and Number				10f. Zip Co	de		1	l0g. Citizen o	of What Cou	untry?
with the Maryland ns 23a or 28a-f sho be notified at once.	ä	616 Longwood Cour	:t			2	21040)		U	SA	
h with	Funeral Director	11. Marital Status	12. Was Decede						(Specify Yes or No erto Rican, etc.)		Race - Ame White, etc.	rican Indian, Black,
hours after death with the Maryland matural", or items 23a or 28a-f she Examiner must be notified at once	Ē	1 Never Married 2 Marrie 3 XWidowed 4 Divorce		2 🗓 No		Yes 2X				Sner	city: Wh:	ita
irs afte	Š	15. Decedent's Education (Specify	or Dates:	ompleted)	16a. Decedent				of work done		of Business	
64 3	Completed	Elementary/Secondary (0-12)	College (1-4 c		during mo	st of working	g life. DO	NOT use	retired)			
orthin ene.	Idm	12			Cu	stodia					h Sch	001
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene. 127 is marked other than " umatic event, the Medical	ပ္သိ	17. Father's Name (First, Middle, Las	•						ame (First, Middle,			
12 Id be fenta	To Be	Charles R. Hank	La (Type, Print.)		19b. Mailing	Address (5	Street ar	OTTA DOTTA	Jane Chi	Lares: mber, City or	S Town, Stat	e, Zip Code)
AD 2 shou and 1 street is and 1 street is	1	Robin S. Gaston							Edgewood.			
		20a. Method of Disposition		20b.	Place of Disposi crematory or oth	tion (Name c			Date			r Town, State
Baltimore, permit. Pages I ar Department of Hec Important: If ite		1 Burial 2 X Cremation 3 4 Donation 5 Other Specif		Me	tro Cre	matory	7 Inc	c. 0	4/26/11	Ba1	timor	e, Maryland
alti rmit. spartm ports		21. Signature of Funeral Service Lice	Thomas	Grego	r 22. N	ame and Ado	dress of	Facility	v Of Mary	land.	Inc.	
		Thomas X	7~~		29	9 Fred	leri	ck Ro	ad Baltin	nore,	Maryl	and 21228 Approximate Interval
Physiciar /Medica	100	21. Signature of Funeral Service Lice 23a. Part I. Enter the disease, of confailure. List only one cause on the confailure.	each line. Hypo B. Disease	ertens	sive Ath	erosc.	lero Rr	tic (Cardiovas	cular	of filedit	Between Onset and Death
xamine		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor			by HI	, 11	actui				
	<u>_</u>	Sequentially list conditions,	Due to (or as a cor	a house done of								
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uted d ansit	Examiner	events resulting in death) Last	Due to (or as a cor	sequence c	of):						***	
be executed sician and unial - transit	dical	▼ UNPENDED	AMENDED 2	3a,pt.	II,27,2	8a-f 1	per	me g	915 5-2-1	1 vt		
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate bin 24 hours after death. The Functal Director: After this certificate has been signed by the attending physimpletely filled in by the functal director, page 2 should be detached for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outc	ome of preg		al death	3	Ectopic pre	egnancy	23d. Da Mon	te of delive th	ry Day Year
X 6 th cert ttendir r use a	icia	past 12 months? 1 Yes 2 ✓ No 9 Unknow	_ " "	at time of de	oth =	er (Specify)						
. Bo he deat y the at hed for	hys	Part II. Other significant conditions	9 Olikilowii	ath but not r	oculting in the u	nderlying car	use give	n in Part I	23e Did t	obacco use o	contribute to	o the cause of death?
P.O. es that the igned by be detach	<u>۾</u> ا	Chronic Obstr	-		_	idenying cat	use give	iriiri aiti.				obably 4 🗸 Unknown
cords, F aw requires as been sign 2 should be	Completed	Onionio voci	decire he	-B	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				24a. Was			utopsy findings available
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ian: The certificate extor, page	ပ္ပိ	25. Was case referred to medical				26.F	Place of	Death (Ch	1 ✓ Yes eck only one)	2 No	1 🗸 \	es 2 No
Vital ysician: his certifi director,	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	tient 2	ER/Outpatient	3 DOA	Oth	er ₄ N	ursing Home 5	Residence	6 Oth	er:
Of Of Ving Phy. After the funeral		27. Manner of Death	28a. Date of Ir (Month, Day	njury r,Year)	28b. Time of Ir	· ·		t Work?	28d. Describe	how injury o	ccurred	
Sion Attendi r death. rector:	atio	1 Natural 5 Pending 2 X Accident Investiga	3-15-		unknown			2 X No	Subje	ct fe		
Division of Vital Records, piptal or Attending Physician: The law require ours after death. For the this certificate has been sirelled in by the timeral director, page 2 should be	Certification:	3 Suicide 6 Could no determin	ot be		ome, farm, stree esidenc e	-	fice build	ling, etc.	or Town,	State) 6	16 Lo1	tural Route Number, City
Fospita † hours *uoera !ly fille	· •	29a. Certifier	cian: To the best of				ne date:	and place	and due to the cau			ated.
Divis To the Hospital or A within 24 hours after the Fuoeral Dire completely filled in bir	Medical	one) 2 Medical Examin	er:On the basis of ex and manner state	amination a	nd/or investigati	on, in my op	inion, de	eath occurr	red at the time, date	and place, a	and due to t	he cause(s)
F . ¥ E 3	¥	29b. Signature and title of certifier	and manner state			29c. Li	cense n	umber		29d. Date	signed (M	onth, Day, Year)
		(arae	A all	au		0	C.M.I	Ξ.		April 22	2, 2011	
perd		30. Name and address of person who						и:	MD 04000			
			ant Medical Ex				eet, Ba	altimore	, MD 21223			
Regi		31. Date filed (Month, Day, Year) APR 2 8 20	32/Regist	rar's Signati	. par	Les !						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clara H. Dyson 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Union Memorial Hospital (E.R.) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 6. Sex Days FEB 23 1 🗆 M 2 🗶 F Months Hours Min. 1922 **Director** 215-16-2746 89 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d, Inside City Limits with the Maryland 10c. City, Town or Location must be notified at Director N/A MD Baltimore 1X Yes 2 No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 714 N. Belnord Avenue 21205 USA items ? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Force Black White etc. 0 δ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Completed Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 유 Public Schools 12 Teacher's Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Douglas Lizzie Harris traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 N. Belnord Avenue Robin L. Dyson, daughter Baltimore, MD 21205 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Woodlawn Cemetery 04/30/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility MacNabb Funeral Home, P.A. Sers 301 Frederick Road Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ MYOCATA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner 96465 -ORONA if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami IABETES and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 use as the IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death the 9 Unknown detached 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 6. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and itle of certifie 29d. Date signed (Month, Day, Year) 0053373 21215 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Year) APR 2 8 2011 32. Registrar's signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician ?** M 3:52 AntHONY DARDUZZI APRIL 2011 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOHNS HOPKIND BANKEW MEDICAL CENTER N/A BALTIMURE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Year) 1 M 2 □ F 87 01-17-1924 217-14-6237 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notified at 1 X Yes 2 ☐ No Baltimore Maryland N/A Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21206 4518 Furley Avenue Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status orces r Black, White, etc. after 1 Never Married 2 Married 1 XYes 2 If Yes, Give Maryland 21215-0036 ö 1 ☐ Yes 2 No White Specify ģ 3 Widowed 4 Divorced within 72 hours Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Government Project Manager 10 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F Be Caroline Montanari Frank Dardozzi 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 Is I 1227 Walters Mill Road Forest Hill, Maryland 21050 Mr. Mark Dardozzi – Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or Most Holy Redeemer Cemetery 04-28-2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) I Funeral Service 22. Name and Address of Facility 21. Signatur 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 Munes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** S DAYS TRACT URINARRY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-tran and Due to (or as a consequence of): Box 68760 the attending physician certificate be Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo. in the past 12 months? Month Day Year 5 Other (specify) P.O. I Tyes 2 No detached 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 ☑ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page certificate 1□ Yes 2 Z No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 1 🔲 Yes 2 ER/Outpatient 3 DOA this 2 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation (Month, Day Year) Injury М 2 Accident 1 ☐ Yes 2 ☐ No death the within 24 hours after death To the Funeral Director: 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide ō Hospital 29a. Certifier 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) APR 28 2011

MARC LAROCHELLE MD 4940 32. Registrar's Signature Bark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

EASTERN AVENUE

RES-000

BALTIMORE

APRIL

MD

21224

23 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rudolph Daye John April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton Prince George's 7205 Milligan Road 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours Min (Month, Day, Year)
Jan 17, 1929 218 24 0932 81 Director Washington DC Usual Residence of Decedent Silvers 50 m.c. I and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XX No MD Prince George Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7205 Milligan Road 20735 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc. 1 Never Married 2 X Married If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter W. Daye, Sr. Mary E. Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Elizabeth Daye (Wife) 7205 Milligan Road, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1

A Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Resurrection Cemetery April 26, 2011 Clinton, MD 21. Sign tun of Funeral Service Ligenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Man Ferry Road, Clinton, MD20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a d **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Wondry been signed by the attending physician and should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Live Betal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 4 ☐ Pregnant at time of death g ☐ Unknown Other (specify) 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed W/d 2 No 1 Yes 2/2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 \quad Yes 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cept 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) exus 1/11 ng 1/12 Fr. a rithagha, Mg

Registrar DHMH 17 Rev 7/2009

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32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

an Edward Do	-	State of Maryland / Department of Certificate of Certificate		nd Menta	Hygiene	Reg. No.	201	3568
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of D)eath	V	3. Time of Death
edical Examii	1114	Brian Edward Doyle			Month April 24	Day , 2011	Year	1328 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town,		eath		. County of De	eath
		Howard County Hospital	Columbia				loward	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye	ear If Under 2 ays Hours	2.0		lFo	Birthplace (State or reign
Director		212-88-3742 13km 2 F 39 Yrs		ays Hours	Apri:	161	972	Country) Md
	l	Usual Residence of Decedent						10d. Inside City Limits
e e		10a. State 10b. County 10c. City, Town or Local	tion					1 X Yes 2 No
f sho	힏	Md Howard Laurel	10f. Zip Code			I 10a Citi	izen of What C	
Mary	Director	10e. Street and Number	20723			_	SA	,
th the		9001 Dumhart Rd			(Specify Yes or	<u> </u>		merican Indian, Black,
tems	Funeral	1 Never Married 2 K Married Armed Forces?	res, specify Cub	oan, Mexican, Pu	uerto Rican, etc.)		White, etc	
er des		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2X	No specify:			Specify: W	hite
urs afi tural'	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Deceder	nt's Usual Occup	pation (Give kin	d of work done	16b.	Kind of Busine	ss/Industry
72 hor	ig.	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working li					
O36	립		Equipme				Privat	e
Baltimore, MD 21215-0036 semit Pages I and 2 should be filed within 72 hours after death with the Maryland bearnitent of Fletath and Mental Hygiene. Comportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last)			iame (First, Midd Ley Nor		Surname)	
121 d be f lental	o Be	Frank Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (St		r or Rural Route		ity or Town, S	tate, Zip Code)
shoul and N 7 is m		Anthony Anastasi /Brother-in-law 6516			kridge,		21075	
and 2 (ealth term 2		20a Mathad of Disposition 20h Place of Dispo	sition (Name of	cemetery.	Date	20c.	Location - City	y or Town, State
OFE ges 1 it of H		1 Burial 2 X Cremation 3 Removal from State Fort Linco	nerpiace) oln Cren	natory	5/2/11	Br	entwoo	d, Md
Baltimo permit. Pages Department o Important:		4 Donation 5 Other Specify.			Fort Lin	coln	Funera	1 Home
Balti permit. Departm Imports injury o		Vreto Marcis 34	401 Blad	densburg	g Rd Br	entwo	ood, Md	20722
Physician		28a, Part I. Enter/the disease, or complications that caused the death. Do not enter						Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Alcohol And Narcotic	:(Heroin	ı) Intoxi	cation a	ind co	ocaine u	se Death
_xammet		or condition resulting in death) Due to (or as a consequence of):						
	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	ш	cause. Enter Underlying Cause						
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence or):						
be executed ician and urial - transit	dical	d. AMENDED 23a,27,28a-f,8	-015 5_1	13_11 cr	n			
	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	3913 3-1	13-11 31		23	3d. Date of del	ivery
6876(certificate nding physise as the b	cian/Me	23b. Was decedent pregnant in the	etal death	3 Ectopic p	regnancy		Month	Day Year
Box 687 e death certific the attending I ed for use as the	sici		Other (Specify)			-		
W - 5-91	Physic	Part II. Other significant conditions contributing to death but not resulting in the	underlying caus	se given in Part	I. 23e. D	oid tobacco	use contribut	e to the cause of death?
Records, P.O. I The law requires that the cate has been signed by the	Š				1]Yes 2	No3	Probably 4 V Unknown
ds, equire een si ould b	Completed					Vas an utopsy		re autopsy findings available r to completion of cause of
COF law r has b	헏				—	erformed?	deal	
tal Re		25. Was case referred to medical	26 PI	ace of Death (C		es Z		100 2
ita irecto	Be	examiner? Hospital: 1 Inpatient 2 FR/Outpatier		Lou	Sursing Home 5	Resid	lence 6 (Other:
of Vital Records, ing Physician: The law required the remains certificate has been sureral director, page 2 should the page 2 should the real director, page 2 should the real director.	5	1 Yes 2 No Impatient 2 Elocateurs 27. Manner of Death 28a. Date of Injury 28b. Time of	f Injury 28c. I	Injury at Work?	28d. Desc	ribe how in	jury occurred	
_ = . ~ = .	tion	1 Natural 5 Pending (Month, Day, Year) 1 Natural 5 Pending Fd 4-24-11 Fd 12:4	44 am 1	Yes 2 X N	OHAHO			
Division tal or Attendir rs after death. al Director: A	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		ce building, etc.	28f. Locati	ion (Street vn. State)	and Number of	or Rural Route Number, City
DIVI pital or ours afte teral Dir	Certification	4 Homicide determined (Specify) Residence						(eaton Rd.
Division of Vital In Hospital or Attending Physician: hin 24 hours after death the Funeral Director: After this certifingletely filled in by the funeral director,	Sal	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig	urred at the time	e, date and place	e, and due to the	cause(s) a	and manner as	stated. to the cause(s)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	and manner stated.		ense number				(Month, Day, Year)
	Σ	29b. Signature and title of certifier		.C.M.E.	OCME		oril 25, 201	
		Thodore W. K. Jkymed.					,	
		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Ba	Itimore Stre	et, Baltimore	, MD 21	223	
	tate	31. Date filed (Month, Day, Year) 32. P gistrar's Signature	"The same					
Regis			allel		<u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		F	• •	Department of Health and I		e i i e e e e e			
		1 - State Registrar		Certificate of Death	Reg. No.	011 13569			
Physi /Med	dical	1. Decedent's Name (First, Middle, Last	Elias		2. Date of Death Month Day	3. Time of Death 14:46 P M			
Exam	iner	4a. Facility Name (If not institution, give	TAN HOSPITAL	4b. City, Town, or Location of Death BAKTIMOLE	4c.	County of Death			
Funera Directo		5. Social Security Number 6. Se	7. Age (In yrs. last bir		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
death with the Maryland ms 23a or 28a-f ehow	ctor	10a. State 10b. County	A 10c. City, Town	Baitimore		10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
ath with th	Funeral Director	1909 & Be	vedere Are.	104. Zip Code 2123		zen ol What Country?			
or its	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.			
within 72 hours ene. Then "neturel", he Medical Ene.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b. Ki	nd of Business/Industry			
and A	Be	17. Father's Name (First, Middle, Last)	Malaxa	18. Mother's Nan	ne (First, Middle, Maiden	1 1			
2 should and Mei is mark	မှ	19a. Informant's Name/Relationship (7)	NUSON 196	Mailing Address (Street and Number or Ru	ral Route Number, City o				
Dalltimore, IN permit. Pages 1 and 2 Department of Health important: if Item 27 i eny injury or other tra	L	Linda 500 20a. Method of Disposition	- compto	Disposition (Name of y, crematory or other place)	Date 20c. Lo	ocation Lity or Town, State			
Dall(IMOr bermit: Pages Department of mportent: if It my injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	1 Gude:	of Faith 412	6/11 Ba	Himore, Mo			
Department of the position of		21. Signature of Funeral Service Licens Augustus	Trans	2.1 9.2 VV NOV	Figures Ho n Ave, B	anten NID 21216			
Physiciar /Medica	_	23a. Part 1 - Iller she disease for complishors, or heart lailure. List only of Immediate Cause (Finat disease or condition resulting in death)	ASCVD	not enter the mode ol dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death			
Examine	r.	Sequentially list conditions,	Due to (or as a consequence						
be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, basing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of the cons	·					
	edicai								
To the Hospitel or Attending Physician: The law requires thet the death certifical within 24 hours after death. To the Funerel Director: After this certificale has been signed by the attending phycompletely tilled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time ol death 9 □ Unknown		23d. Date of delivery Month Day Year				
w requires thet been signed by should be detailed	þ	Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.							
ysician: The law recipied to the security of t	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
ysician:] ysician:] is certifice director, p	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	lospital: 1 □ Inpatient 2 XER/Ou		ome 5 Residence	6 □Other (Specify)			
nding Ph ath. r: After th e funeral	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. 1	Time ol 28c. Injury at Work? M 1 \[Yes 2 \] No	28d. Describe how injury occurred				
To the Hospitel or Attending Physicial A within 24 hours after death. To the Funerel Director: After the completely tilled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, la building, etc. (Specify)	rm, street, lactory, office	28l. Location (Street an City or Town, State	d Number or Rural Route Number,)			
e Hospit 24 hours Eunere letely fille	edicai (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	dor investigation, in my opinion, death occurred	, and due to the cause(s) ured at the time, date and	and manner as stated. I place, and due to the cause(s)			
To th within To th compl	Me	29b. Signature and title of certifier	- physic	29c. License number	29d. Dai	te signed (Month, Day, Year)			
\		30. Name and address of person who co		$\begin{array}{c c} 7 & 7 & 7 & 7 & 7 & 7 & 7 & 7 & 7 & 7 $	LOCH RAVE	Cil 22,2011 Si Boverado 11239			
\	tate	TERESA MUA 31. Date fited (Month, Day, Year)	/	BAKT	mo 2	1239			
Regis	tate trar	ADD 9 8 7		parkel		6			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 APR I SHARON **ESCANN** РМ 11:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 119 RIVER OAKS CIRCLE BALTIMORE **BALTIMORE** 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Hours Min. 06/01/1945 Country) **Director** 65 MD 220-42-7142 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 RIVER OAKS CIRCLE 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify: Specify: WHITE 3 Widowed 4 XXDivorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) SELF EMPLOYED MORTGAGE LENDER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MORRIS **ESCANN** permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic GERTRUDE THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ILISE FRIEDMAN/DAUGHTER FOXCREEK COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 04/27/2011 RANDALLSTOWN, MD 22. Name and Address of Facility OL LEVINSON & BROS., INC. of Funeral Service Licente PIKESVILLE, MD 21208 <u>8900 REISTERSTOWN ROAD.</u> 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani ELANOMA disease or condition Medical resulting in death) Due to (or as a consequence of): MONTHS Examiner X METASTAGES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy \square Pregnant at time of death 5 Other (specify) Month Day Year ∃ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 perform 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 5 \square Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number D29373 29d. Date signed (Month, Day, Year) 25 ause of death (Item 23a) (Type, Print) RD, SUITE 200 LUTHERVILLE) MD 21093 31. Date filed (Month, Day, Year, 2. Registrar's Signature State

ORIGINAL

APR 28 201

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Thomas Fulton April 8 2011 8:20 PM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 1903 Indian Head Road Baltimore Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Nov 19, 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | if Under 24 Hrs. Hours Months Days 1 X M 2 □ F 113-20-0676 83 Hungary Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1903 Indian Head Road 21204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ I If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No white Specify. Specify: 3 ₩ Widowed 4 □ Divorced **'**46-47 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) professor physics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Fulton Irene Weisz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Fulton/daughter 1903 Indian Head Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONGEST 15 7RS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c If was outcome of preor

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

Department of Health and Mental Hygiene in Important: If Item 27 is marked other than in any injury or other traumatic event, Item Man price.

Pages 1 and 2 should be innent of Health and Mental

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Examiner Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar the. aftending p IF FEMALE

Physician/Medical Completed by Be Medical Certification: To

signed I

certificate has

After this certific funeral director,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

within 2

23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	It	1	ildeath 3 ⊟ E		pecify)		23d. Date of delivery Month Day Year			
Part II. Other significant cor ALZHEI		atributing to death but not res	ulting in the unde	, ,			co use contribute to the cause of death?			
						24a. Was an autopsy performed 1 \(\text{Yes} \) 2				
25. Was case referred to me	fdical	26. Place of Death (Check only one								
examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Mann	ending vestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred			
	ould not be etermined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street fy)	28f. Location (Street City or Town, St	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		sician: To the best of my knoner: On the basis of examinating and manner stated.					e(s) and manner as stated. and place, and due to the cause(s)			

State Registrar

31. Date filed (Month, Day, Year) APR 28

29b. Signature and title of certifier

NEWMAN ,mo 32. Registrar's Signat

newman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUTHSRVILLE 21093 MAD

29d. Date signed (Month, Day, Year)

RD # 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of									12572
	State of Maryland / Department of Health and Mental Hygiene O 1 357 Certificate of Death Reg. No.										10014		
Decedent's Name (First, Middle, Last)							2. Date of De				ath Day	Year	3. Time of Death
	Physicia Medic	al	Bets	4		Fishe	her Month				15	2011	6:00pM
	Examin	_	4a. Facility Name (if not institution,	give street and numb	ber)		4b. City, To	own, or L	ocation of Death			inty of Death	
			Charlestown C	are Center	7 1 // 1-	a to testinate of a A	Cat		rille If Under 24 Hrs.	8. Date of Bi		1timor	e place (State or Foreign
	Funeral	ľ	·	6. Sex 1 ☐ M 2 🂢 F	7. Age (In yrs. Ia 89	Yrs.			Hours Min.	Month, Da	4 Year) 192	1 New	York
	Director	ŀ	078-16-1550 Usual Residence of Decedent		- 07						.,		
	shov dat	호	10a. State 10b. County		10c. City	, Town or Loc	cation						10d. Inside City Limits
	Mary 28a-f otifie	irec	MD Balt	imore		Cato	nsvill						1 🗆 Yes 2 No
	h the	a D	10e. Street and Number	J T	# CD / 1 /		10f. Zip (228			of What Cou	intry?
	th wit	Funeral Director	715 Maiden Cho		dent Ever in U.S	13 1	Mas Decede			ecify Yes or No		Race - Ameri	can Indian.
	r dea or iter niner	by Fu	11. Marital Status1 Never Married 2 Mari	Armed For	ces?	1			panic Origin? (Sp , Mexican, Puerto	Rican, etc.)	14.	Black, White,	
9	s afte ral", o Exan	q pe	3 X Widowed 4 ☐ Divorced	If Yes Give				X No	Specify:		Specify: white		
2-0	hour hatu	Completed		nt's Education est grade completed)		16a. Deced	lent's Usual kind of work	Occupat	ion ring most of wor	king	16b. Kind	of Business Ir	ndustry
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		21. Signalur of Funeral Service	icenses de 1	rector	: St	Name and	adro	my Boar	d 655 W	. Balt	imore	Street
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23b. Was decedent pregnant in the past 12 months?								230	Month	Day Year			
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9. 0.	that the											use contribute to the cause of death?	
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Division of Vital Records, P.O.	al or safte									City or Town, State)			
	lospit 4 hour unera ed fille	Medical	(Chaok 2 Medical	g Physician: To the b	eie of examination	on and/or inve	stigation in r	my opinio	 n. death occurred 	at the time, dat	e and place, ar	nd due to the	cause(s) and manner stated.
	the H thin 24 the F	₩	only one) 3 Certifyin	g Nurse Practioner:	To the best of n	ny knowledge,	death occur	red at the	time, date and p	lace, and due to	the cause(s) a	nd manner as signed (Monti	stated.
_	5 wit		29b. Signature and title of certifie	1	2 ·	04 10					, , ,	1, 1.	
	•		30. Name and address of person	2 Bowl		m 23a) (Type.			377		1 4/	10/11	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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-	Medic Examir	cal	Raymond 4a. Facility Name (#	not institution, g	Favali			4b. City, To	wn. or L	ocation of	Death	April	T	201 Year		9:1	1 AM
-	<i>,</i>		7709 01d					Bethe	esda				N	lontgom	ery		
	Funeral Director		5. Social Security N 311-16-1. Usual Residence of	567	. Sex 1 X M 2 D F	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours		Date of Birt (Month, Day Oril I	h (4	9. Bi	ountry L	ce (State or Virgin	Foreign ia
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36	after death al", or items xaminer m		11. Marital Status 1 ☐ Never Marr 3 🌣 Widowed		Armed I 1 X Ye If Yes, 0			S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:						14. Race - Am Black, Whi			
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by		15. Decedent's cify only highest	grade complete		(Give .	lent's Usual C kind of work of O NOT use re	done du		of working			bb. Kind of Business Industry			
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38760	rtificate ling phy e as the	/Med	IF FEMALE:		00-26												
Box 68	To the Hospital or Attending Physician: The law requires that the death certific thin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent in the past 12 r 1 Yes 2 0 9 Unknown	nonths?	23c. If yes, o 1 Liv 4 Pre 9 Un	e Birth 2 egnant at tim	Fetal death 3	Ectopic pred Other (speci	gnancy fy)					23d. Date of de Month	elivery Da	y Y e	ar
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Division of Vital Records, P.O.	to the hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Plac	ce of Injury - ding, etc. (Sp	At home, farm, streecify)	et, factory, of	fice		28f.	Location (S City or Town	Street and Number or Rural Route Number, vn, State)				
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			30. Name and addre	ss of person who					010	04			Apr	i1 13,	201	L J.	
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Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07:40A James S. Garrett 201 nr, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice/Northwest Hospital <u>Randallstown</u> Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months Apr Pay, Yer 927 Maryland 84 **Director** 220-18-7044 Usual Residence of Decedent or 28a-f show 10b. County the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 55 Wade Avenue 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white If Yes Give Completed 3 Widowed 4 X Divorced WWII Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) interior design display artist æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked ည Rudy Garrett Daisy Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 224th Street Pasadena, MD 21122 Francine Garrett-Meeks/daughte permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 NO Other (Specify) in state 21. Signa ure superal Service Licensee Director State and Address of Jacks and 655 W. Baltimore Street nn 21201 Baltimore, MD 23a. Part t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ d Lh Tas disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 the attending plant for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No ed by the a 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 🔼 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier D34053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 Aviation Blud 2106

Registrar

State

31. Date filed (Month, Day, Year)
APR 2 8 2011

Registrar's Sign

Damon 11-03106 Griffin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day April 24, 2011 0222 hrs Damon Griffin Medical Examiner 4c. County of De 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4200 Rokeby Road **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Country) MD Foreian 10/14/85 Months 214-13-2753 Director 25 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Baltimore M 10a, State 10b. County N/A 1 X Yes 2 No MD 28a-f show notified at once. after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21207 USA 7 Walden Maple Court 238 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noor items Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) African 1 Never Married 2 Married 1 Yes 2 X No Specify: Amer. 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Yeer "natural", ₫ Baitimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours a
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natura 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Construction Elementary/Secondary (0-12) College (1-4 or 5+) Laborer 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ivv Williams Charles Canty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ Walden Maple Court, Baltimore, MD 21207 Ivy Williams/Mother 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Mt. Zion cem. 1 Burial 2 Cremation 3 Removal from State 4/30/11 Balt.,MD 4 Donation 5 Other Specify 22 Name and Address of Facility Hari P. Close F.S., PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service L 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Madical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury maximulated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, talor Attending Physician: The law requires that the death certificate be 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed' Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene ٩ 2 No 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot 1 Natural n 24 hours after com...
he Funeral Director: A FOLIND 1 Yes 2 ✔ No Pending Apr 24, 2011 0217 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 4200 Rokeby Road, Baltimore, MD determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 24, 2011 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OVMU Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7202 Waldman Avenue Baltimore Co. Edgemere 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Aug. T2, Year)931 1 M 2 52 F MaryTand 213-28-3174 79 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Edgemere 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21219 United States 7202 Waldman Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Baltimore County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Department Medical Secretary 12 Years Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Elena Nicolai Guido DiMuzio Husband 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Russell G. Glashoff 7202 Waldman Avenue Edgemere, Maryland 21219 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombmen or other place Holly Hill Mem. Gdns. 4/26/2011 Middle River, MD 21. Signa e of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dumdalk Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 2 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy his certificate hil director, page performe 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes မှု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending in 24 hours after the Funeral Director; After Funeral Director; After Funeral filled in by the fur 1 \square Yes 2 🗌 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number ned (Month, Day, Year) and address of person who completed cause of (Type, Print)

State Registrar

APR 28

32. Registra s Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Gregory Allan Georgieff 2:50 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Co. Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1X M 2 □ F Hours March 3, 1947 219-50-4734 Indiana 64 **Director** Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 Yes 2 No Dundalk MD <u>Baltimore</u> ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8158 Kavanagh Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working I Hygiene. United States College (1-4 or 5+)

3 Years Elementary/Seconday (0-12) 12 Years Mail Carrier Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve မ Dorothy M. Smith James A. Georgieff Wife 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21222 Mrs. Elizabeth J. Georgieff 8158 Kavanagh Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2X Cremation 3 Removal from State Hilltop Service Corp. 4/29/2011 Towson, Maryland Ronation 5 Other (Specify) f Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beath Immediate Cause (Final Ph_sician/ CANCER disease or condition Medical resulting in death) Dua to (or as a consequence of **Examiner** Sequentially list conditions, <u>e</u> if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live a Company at time of death in the past 12 months? Tyes 2 □ No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury s affer death. 2 Accident
3 Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by ☐ Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth, 1 3. 2011 05 **Physician** ESTHER BELLE GOLDSTEIN /Medical 4c. County of Death am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner COURTLAND GARDENS BALTIMORE **BALTIMORE** Birthplace (State or Foreign Country) If Under 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 X F 95 220-09-3688 Director 03/30/1916 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show ns 23a or 28a-f shov must be notified at MD BALTIMORE BALTIMORE Director 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7920 SCOTTS LEVEL ROAD, #247B 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify by Specify: WHITE 3XXVidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **TELLER** BANKING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h LEAH **GROSS** ို SAMUEL MEHLMAN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. 2201B WOODBOX LANE BALTIMORE, MD 21209 LINDA LEVINSON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS 04/27/2011 BALTIMORE, MD 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. of Funeral Service Aicense 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause if each line. Immediate Cause (Final **Physician** 2Q. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown signed by the detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 9 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 21 No Hospital: Other: 4 Nursing Home ို 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Marner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 24 hours after death. 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 Kelve UNII 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 731 Clarence M. Henson Medical 4a. Facility Name (if not institution, give street and number, Examiner . City, Town, or Location of Death 4c. County of Death More 1 Year If Under 24 Hrs. **Funeral** Date of Birth
July 16, 1942 9. Birthplace (State or Foreign Days 1 X M 2 D F **Director** 219-38-6450 68 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD **Baltimore** 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1000 N. Gilmore Street 21217 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: black 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence E. Melvin Henson Ursuline Fentress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ursuline Purnell/mother 2725 Walbrook Avenue #502 Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signat of Figure 1 Service Licens State and Address of Jac Board 655 W. Baltimore Street Wirector Baltimore, MD 21201 23a. Pir 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or horizontal failure. List only one cause on each line. Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical rabetes Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death signed by the a id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 s been signal Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has I funeral director, page 2 s autopsy performed' death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 1 No ည Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural s after dea. اعا Director: Afte الا کام 5 Pending 1 Yes Accident Investigation 2 No 6 Could not be 3 Suicide 4 Homicide within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge drafth protect ont one at the fi 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/19/1 Rama Rao. VVNNAM 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) State 8 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

17 & 18 PER ANA BD G923 1/30/2011 JH
State of Maryland / Department of Health and Mental Hygiene 2 0 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ADC 11 201 Phillip J. Haupt Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Dec 11, 1934 1 🌠 M 2 🗆 F Months Days Hours Min. **Director** 218-28-7639 76 Maryland Usual Residence of Decedent nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Director 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 326 Sunray Court 21009 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 loader grain elevator Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ဂ NARY JACOB HAUPT HAUPT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Haupt/son 326 Sunray Court Abingdon, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖁 Other (Specify) in state Sign fur of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause of each limit. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any same land cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 28 Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause.

Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signat pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g914 4-28-11 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.... Date of Death
 Month 2011 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1:34 James Gerald Holgate 10 April /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore St. Agnes Hospita 8. Date of Birth (Month, Day, Ye Sep. 11, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Country) New York Hours Months Days 1**X** M 2□ F 54 1956 099-50-0130 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evantial Countries and once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director Baltimore Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code 1316 Dorchester Avenue 21207 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X1Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Lineman Utilities 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Muriel Van Etten Gerald Holgate ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 1316 Dorchester Avenue Baltimore Maryland 21207 Robin Kinzer-POA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Apr. 15, 2011 Glen Burnie Maryland Atlantic Crematory 4☐ Qonation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 if 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final failure anknewn hepatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Failure renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending PhysIclan: The law requires that the death certificate be executed Coagulopathe attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 212No 1 ☐ Yes 2 ☑ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner1 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after ucc...he Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P23628 4/10/2011 OKIV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore, MD 21229 900 Catan M. Stagzak 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:35P M Mary Madgalene Smith Harrison Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HAME INTER Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 🗓 F Dec. 22, 1932 Months Hours North Carolina 210-32-7950 Director 78 Usual Residence of Decedent shov 10a, State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Examiner must be notified 1 ☐ Yes 2 🛣 No Charles La Plata Maryland ō 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? items 23a Funeral 20646 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-003 "natural", Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 11 Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sadie Smith Leroy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11204 E. Barnswallow Pl., Waldorf, MD 20603 Doretha Harrison (Daughter) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Crestview Memorial Cemetery 4 🗆 D 5 Other (Specify) Apr.30,2011 Roanoke Rapids, NC 21. Sign ure of F eral Service License 22. Name and Address of Facility Cofield Mortuary 501 W. 3rd St., Weldon, NC 27890 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a conse sician and burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No detached for Month 9 Unknown P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print) . Name and address of person 46695 31. Date filed (Month; Day, -Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh g915 5-12-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 Elmer 2011 & Pm Μ. Houck Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Overlea Health and Rehabilitation Center Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1**XX** M 2 \square F 96 216-10-6036 Months Days Hours Min september 4, Director 1914 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 925 Rosedale Avenue 21237 USA 11. Marital Status 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Completed by Black, White, etc. "natural", or 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Inspector Martin Marietta Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ item 27 is marke other traumatic Unknown Houck unknown f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Simms/Friend 925 Rosedale Avenue Baltimore Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. Most Holy Redeemer 5/2/11 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Ponset and Death Physician/ disease or condition resulting in death) Medical Due to for as a cons 2 weeks **Examiner** Sequentially list conditions. if any, leading to immediate Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **N**0 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 5 Pending Accident

Accident

Suicide

Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of q 31. Date filed (Month, Day, Year) State 8 2011 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Hummer PM 3:10 uisa APKIL 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months 218-28-0060 84 **Director** November 26, 1926 Italy Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Director N/A ral", or Items 23a or 28a-f s Examiner must be notifled 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3913 Kenyon Avenue 21213 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 X Widowed 4 Divorced Specify: White "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F Unknown Borgognoni Maria Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Licia Brown/ Daughter 3209 White Avenue Baltimore, Maryland 21214 Department of Healt important: If Item 2 any Injury or other or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 4/30/11 Baltimore Maryland 21. Signature of Fuperal Service Licensee Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY Immediate Cause (Final FAILURE **Physician** WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** WEEK EMBOLI FAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 NO 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? funeral director, page 2 2 1000 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 INo 2 ER/Outpatient 3 DOA မ After this 27. Manny of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 🗌 Yes 2 No 2 Accident s after death filled in by the 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1785-000 2011 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001 11595

State Registrar CHRISTOPHEX

APR 2 8 2011

BACH

4940 Eastern Avenue, Baltimore, MD, 21224

M.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HOPE Month -78 11:13/ Zearil UCY Medical 4a. Facility Name (if not institution, give Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWERE (Ieneral Cohunbic If Under 24 Hrs. 7. Age (In yrs. last birthday, If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Davs Hours Country) Director n MD Apr 6, 2011 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified of 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 - Yes 2 - No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? by Funeral 21045 U.S.A. 6153 Committment Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Wkite If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Infant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jessica Ann Schlieve Carl S. Hashbarger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Hashbarger 6153 Committment Ct. Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 🛅 Cremation 3 🔲 Removal from State Apr 12, 2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory, LLC of Fundral Service 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Sian 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between sh ck, or heart failure. List only one cause on each line. Immediate Cause (Final set and Death EXTRERM Physician/ disease or condition resulting in death) Medical Due to (o as a consequence of: Examiner howers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events.) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedetached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 W No After this certificate has page 2 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural iniury 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after deatl Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

21044

5155 Edar Lane Cohurba

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-02804 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kyle Bailey Johnson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Modical Examiner Ky1e Bailey Johnsen 1411 hrs April 12, 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 10980 Wallace Bowling Lane La Plata Charles 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign AS hington 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 214-21-7874 Director Months Days Hours Min. 1X M 2 F Country) 27 April 28,1983 DC Usual Residence of Decedent 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Charles La Plata Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10980 Wallace Bowling Lane 20646 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White etc. 2 X No Yes of Hygiene.

The Medical Examiner in the Medical Exami 3 Widowed 4 Divorced if Yes. Give Year 1 Yes 2 X No specify: White Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Plumber Plumbing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Lee Johnsen Sharon Cleaveland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Johnsen/Father 10980 Wallace Bowling Lane, La Plata, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) St. Ignatius Cemetery 4/19/2011 Port Tobacco, MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name end Address of Facility M00945 AREHART-ECHOLS FUNERAL HOME, PA David C. Echols per dvr 20646 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; shocks of heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Ethanol and Oxycodone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last n and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical x AMENDED 21 per fh g914 4-28-11 vt 23a,27,28a-f per me g915 5 g physician the burial -**X** UNPENDED per me g915 5-2-11 vt Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending or use as the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. <u>6</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division Director: 5 Pending 1 Yes 2 X No fd 4-12-11 unknown 2 Accident unknown Investigation l in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) 10980 Wallace determined (Specify) Homicide home LaPlata, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death.

To the Funeral Director:

31. Date filed (Month, Day, Year) 32/Registrar's Signature

0

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 13, 2011

29c. License number

OCME

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Patricia Aronica-Pollak MD

arks

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Adelaide Snowden Jones Apr 20, 2011 Year 6:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death **Baltimore** Timonium Stella Maris (Cardinal Shehan Center) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year) Sep 15, 1922 Country) MD 213.20.0506 **Director** Usual Residence of Decedent shov 10a, State 10b. County 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director Catonsville 1 🗆 Yes 2 🗙 No MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 U.S.A. 9 Scotch Elm Ct. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Yes 2 No If Yes, Give Year Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) sales consultant depatment stores Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Matilda Griffith William Snowden Hodges traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mathilde J. Cary Daughter 9 Scotch Elm Court Catonsville, MD 21228 injury or other Baltimore. 20a. Method of Disposition
1 □ Burial 2 💢 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date netery, crematory or other place)
Atlantic Crematory, LLC Apr 22, 2011 Glen Burnie, MD Sonation 5 Other (Spedity) 22. Name and Address of Facility Stack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ign ure of Funeral Service MO0535 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause and ach line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician. disease or condition resulting in death) Medical Due or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ADELAIDE 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Natural 5 Pending 2 🗌 No after death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination an Certifying Nurse Practioner: To the best of my within 2

To the 3 🗆 only one 29b. Signature and title of certifie 29c. Liteense number 29d. Date signed (Month. Day, Year) 20 30. Name and address of person who completed cause of death (Item (3a) (Type, Print) DULANEY VALLEY ROAD TIMONIUM, ERNESTINE WRIGHT 2300 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

A.M.

6:50

2011

APRIL

JONES

			end items 17.18 per State of Maryland / Dep	artment of Health and N	Mental Hygie	ene				
		•		rtificate of Death		2011 13588_				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	<u> </u>	2. Date of Death Month	Day Year 1.3 C 2				
	Medic	al	BARBARA JONES			25 2011 /25 PMM				
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
_	Funeral		GOOD SAMARITIAN NURSING CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.						
	Director		219-32-0843 1 M 2 X F 74 Yrs.	Months Days Hours Min.	(Month, Day, You 10-31-1					
	now at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits				
	arylar ia-fst ified a	ecto	MD. N/A BALTIMO			1 X Yes 2 □ No				
	or 28	Ρ	10e. Street and Number	10f. Zip Code	10	Citizen of What Country?				
	s 23a	by Funeral Director	3737 CLARKS LANE	21215		USA				
	death r item iner n	Fur	Armed Forces %	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.				
336	al", o	d b	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never New Married 2 Never New Married 1 New Married 1 Never New Married 1 Never New Married 1 Never New Married 1	1 ☐ Yes 2 🗓 No Specify:		Specify: BLACK				
0	hours natur dical l	Completed	15. Decedent's Education 16a, Dece	dent's Usual Occupation kind of work done during most of work	10	6b. Kind of Business Industry				
21	hin 72 ne. than " e Me	E O		OO NOT use retired)	Ĭ	SPECIAL EDUCATION				
2	ed with	0	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma.					
au	be file ental 'ked c	P	RALIEGH N: PLEASANT H. PLEASANTS			DINKINS				
ary	hould and M s mar			ing Address (Street and Number or Rura						
Σ	ealth a m 27 i		DELORES BRADFORD(SISTER) 471	.3 WRENWOOD AVE. B	ALTIMORE,	MARYLAND 21212				
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🖺 Burial 🖈 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition 20b. Place of Dis	osition (Name of matory or other place)	Date 20	Oc. Location - City or Town, State				
Ħ.	it. Pag rtmen rtant: njury		4 Donation 5 Otyler (Specify) NEW CATHE	DRAL CEM. 4-30		BALTIMORE, MARYLAND				
	perm Depa Impo any i			2. Name and Address of Facility PHI 721-27 N MONROE		NERAL HOME, P.A. IMORE, MARÝLAND 21217				
			23a, Part 1. Enter the disease, or complications that caused the death. Do not ent	er the mode of dving, such as cardiac	r respiratory arrest	Approximate				
-	Trysician/		sho, f, or heart failure. List only one cause on each line. Immedia Cause (Final disease Condition Chrowical disease Chro	16structure Pu.	morning	Interval Between Onset and Death				
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):		-					
	LXaiiiiici	P.	Sequentially list conditions, b. Due to lor as a consequence of the control of t							
	led nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury							
	be executed sician and burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):							
	te be exenysician	dical	d							
387	eath certificate to attending phys	~ I	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							
×o	ath ce attend for us	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year				
B	the de by the ached	hysi	1 Yes 2 No 4 Pregnant at time of death 5 to 9 Unknown							
<u>G</u>	requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1	cco use contribute to the cause of death?				
rds,	equire een sie ould b	Completed	THAT TO CELEVILLE	7/ (1 Yes	2 No 3 Probably 4 LOnknown				
CO	law re has be e 2 sh	mple			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?				
m m	hysician: The law in sertificate has to director, page 2 s		25. Was case referred to medical		1 🗆 Yes 2					
/ita	sicial s certi	To Be	examiner? 1 Yes 2 No	26. Place of Death (Check		ce 6 Other (Specify)				
of	ding Phy th. After this funeral o		27. Manner of Death 28a. Date of injury 28b. Time of		28d. Describe how					
on	tendir eath. or: Af the fur	ifica	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Tyes 2 No						
Division of Vital Records, P.O. Box 6876	ital or Attending Physician: The law requires that the death certificate urs after death. In a liter death. In a liter death. In a liter death. Iter is certificate has been signed by the attending physiled in by the funeral director, page 2 should be detached for use as the	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)				
	To the fital or Attendit within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, ar	d due to the cause	(s) and manner as stated.				
	the iin 24 the Fu	Med	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investigation only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a death occurred at the time, date and place	the time, date and pe, and due to the ca	place, and due to the cause(s) and manner stated. ause(s) and manner as stated.				
_	To the within 2 To the comple		29b. Signature and title of certifier Sanku Mi	29c. License number	290	d. Date signed (Month, Day, Year)				
	1,5		On News and address of pages who completed arms of the thirty and the	Print		Tipe 1 -6				
	Dir.		30. Name and address of person who completed cause of death (Item 23a) (Type,	5661 Loch Ra	ven.	Bultime MD				
	Stat	C	or, bate filed (World), bay, rear							
	Registra	r	APR 28 2011 Denve 1. March							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Day 1 4-10 M Thomas Melvin Johnson Jr Por Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Southern Maryland Hospital Clinton 7. Age (În yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 1 Year **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Sept 18, 1947 63 Washington DC Director 577-64-3410 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20904 13116 Collingwood Terrace 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No. 1966 1969 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🗷 No Specify. Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Twelfth Four X-Ray Technician Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Melvin Johnson Sr Daisy King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13116 Collingwood Terrace, Silver Spring MD 20904 Amanda L. Johnson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4/19/11 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville MD 22. Name and Address of Facility Robert G Mason Funeral Home Inc 21. Signature of Funeral Service Licensee Donald R. Gray 1661 Good Hope Rd SE Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not er'e the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ARDIZ Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Vas cula burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed? Yes 2 XXV 1 ☐ Yes 2X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in magnitude to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I comple D52865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W DHMH 17 Rev 7/2009

State Registrar 12150 Annapolis

Glenn Pole MD 20769

Set 200.

Rd

MD

32. Registrar's Signature

Filesco

Michael

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ April 23, 9:03 Lucille Mabel Keyes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 1, 1915 Age (In yrs. last birthday 9. Birthplace (State or Foreign Funeral Min. Days Hours Maryland Director 216-09-4931 96 Jan. Usual Residence of Decedent works Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21204 8415 Bellona Lane Apt. 914 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Milton Gray Mabel Clare Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 B Owens Landing Ct. Perryville, MD 21903 Barbara Ballard/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)
Druid Ridge April 26, Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Pikesville, MD Cemetery 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Funeral Service L Flagle 23a. Part 1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Exphagea Physician/ disease or condition resulting in death) montrs Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-trans attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Other (specify) been signed by the should be detached 1 ☐ Yes 2 ¥ g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Ownha 24a. Was an After this certificate has autopsy the Hospital or Attending Physician; The 1 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 D Other (Specify) WOSPig 2 🔀 No Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State

29b. Signature and title of certifier

31. Date filed (Month, Day APR 28 2)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 N. Charles ST

29d. Date signed (Month, Day, Year)

pril 27 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> April Physician/ 18, 8:40 PM Leone Elizabeth Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Kensington Park Assisted Living Kensington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Oct L. O., 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F ^{Ye}¶ 912 Minnesota 98 468-09-9984 Director Usual Residence of Decedent 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 3616 Littledale Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ₺ Widowed 4 □ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Anna Tetzloff Phillip Gehring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3545 Yuma St. N.W. Washington, DC 20008 (Daughter) Anne E. Boni 20a. Method of Disposition
1 □ Burial 2 ➡ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery cremetery or other place) Metropolitan Crematory 4-20-2011 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility
Metropolitan Funeral Service
5517 Vine St., Alexandria, VA Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 200014 Pnysician/ disease or condition Medical resulting in death) Due to (or as a conse Examiner JALCHOWA Sequentially list conditions, cause. Enter Underlying Exam Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 as the IE FEMALE: use 23c. if yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. rate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be within 24 hours after death To the Funeral Director; Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062999 MD April, 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Montrose 31. Date filed (Month, Day, Year) APR 2 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State
Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician/ 190 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Baltimore Hospita Kandallstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Panana 256.25.784 1 X M 2 □ F Months Days Hours Mer h Da 38 Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits notified at Director MD Pikesville Baltimore 1 Yes 2 No 10e. Street and Number th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 21208 ROCKY Lane filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XAIO Black White etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Black Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, College (1-4 or 5+) Elementary/Seconday (0-12) Coordinator assion 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill Health and Mental Item 27 is marked ဂ Scott David lesane Parvela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pikesville Knuckles /Grandmothrer Rocky permit, Page 1 and 2 Department of Health Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) rematory or other place) 30 Druid Lidge 21. Signatule of Funer Sen ice Licensee Vaugly C. Greene Funeral Services Road Randallotown MD 20133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or con-Medical resulting in death) Due to (or as a conseq.) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be execute and Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ğ Month Day Year been signed by the should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 2 X No Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License numbe

Registrar

State

cause of death (Item 23a) (Type, Print)

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completed

and address of person who

31. Date filed (Month, Day,) APR 28 2011

			ase Type or Pri								-	ble.		
		For State Registrar	Oldio of Wi	arylaria /	•	tificate o				Reg. No.		1	10500	
Physicia: Medic		1. Decedent's Name (First, Middle HELEN	e, Last) MARIE		M	IORGAN			2. Date of De Month	ath Day		Year	3. Time of Death 10:03A M	
Examine		4a. Facility Name (if not institution CRANBERRY CO				4b. City, Tow	n, or Location			4c.	County of	f Death		
Funeral Director		5. Social Security Number 287–16–6182	6. Sex 7. Age 1 ☐ M 2 X X	e (In yrs. last b 88	irthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Bir 3 – 9 – 1				ountry) OHIO	
ryland I-f show ied at	- 1	Usual Residence of Decedent 10a. State 10b. County MD BA	LTIMORE	10c. City, To	wn or Lo		OSEDA	TE					10d. Inside City Limits 1 ☐ Yes 2 🏋 No	
th the Ma 3a or 28a t be notif	ral Dire	10e. Street and Number 1315 CHESACO		PT 130		10f. Zip Coo				10g. Cit	izen of Wh	nat Cou	intry?	
2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Was Decedent of f Yes, specify C	of Hispanic (Origin? (Spe	ecify Yes or No- Rican, etc.)		14. Race		erican Indian,	
ours aft itural",		Widowed 4 ☐ Divorced	If Von Civo			Yes 2		fy:				WH		
nit. Page 1 and 2 should be filed within 72 hour artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natu injury or other traumatic event, the Medical e.	Completed		college (1-4 or 5		(Give I	tent's Usual Oc kind of work do O NOT use retii HOMEI	ne during mi ed)		ing	16b. Ki	iness Ir WN	HOME		
be filed v lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19. FRANK KOTSON ANNA (ULA									AN	1)		
d 2 should alth and N 27 is mail: traumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 POWHATAN BEACH PASADENA, MD 2												
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 4 🗋 Donation 5 🗍 Other (S		ceme	tery, cren	sition (Name of natory or other	olace)		Date 9 – 11				own, State	
permit. F Departm Importa any inju		21. Signature of Funeral Service I		TOAKI	22	. Name and Ad		ility CV	ACH/RC		ALE		NERAL HOME 21237	
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):													
icate be executed physician and s the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans.		IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1											very Day Y ear	
requires that to been signed be should be deta	ρ	Part II. Other significant condition	ons contributing to death be	ut not resultino	g in the u	inderlying caus	e given in Pa	urt I.	23e. Did t				the cause of death?	
sician: The law req certificate has bee irector, page 2 shou	Completed										pr	ior to c eath?	opsy findings available ompletion of cause of	
cian: T sertifica sctor, p	Be	25. Was case referred to medical examiner?	Hospital:				. Place of D	eath (Chec		2 G BT 140	-		100	
g Phy er this eral d	cate: To	1 Yes 2 6	1 ☐ Inpatie 28a. Date of injur (Month, Day		Outpatier Time of injury	28c. I	Other: 4 njury at vork? Yes 2		ome 5 Resi 28d. Describe				Mary Mary Carly	
_ ~	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be		farm, stre	eet, factory, offi	ce		28f. Location (City or Tox			or Rur	al Route Number,	
he Hospit iin 24 hour he Funera ipleted fille	Medical	(Check 2 Medical E	Physician: To the best of Examiner: On the basis of explorers Practioner: To the	kamination and	d/or invest	tigation, in my o	oinion, death	occurred a	t the time, date	and place	, and due t	to the c	ause(s) and manner stated	
To t with To t		29b. Signature and title of certified	I Alia	- m		29c. Lic	ense numbe	094	/	29d. Da	telsigned	(Month,	Day, Year)	
カノ		30. Name and address of person-	who completed cause of de	eath (Item 23a	(Type, F	Print)	fark	Dro	u Gl	en!	Bural	19,0	ud, 2106	
Stat Registra		31. Date filed (Month) Day, Deal)	8 2014 32. Egistra	ar's Signature	4	and			/			ı	. ,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ethel Audrey Meade Year April 23, P. M. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Millersville Assisted Living Well Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth g. Birthplace (State or Foreign 1 - M 2 - F Days Hours May 2, 1917 212-09-3515 93 Director Maryland Usual Residence of Decedent 23a or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 473 Manor Road 21012 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Stock Room Employee Stieff Silver Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Oliver Bull Inez G. Brushmiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 473 Manor Road, Arnold, Maryland 21012 Leslie Higdon Niece 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State 4/27/2011 Woodlawn Cemetery Woodlawn, Maryland 4 ☐ Donation / § ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Burgee Henss-Seitz Funeral Home, Inc
3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Complications of 45 iratim disease or condition resulting in death) Medical Due to or as a consequence of): Examiner 2 months to thrive tallere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and defacthed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after deat.

To the Funeral Director: tter this certificate has b autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) isjan Nohramil CRNV R086053 04/26/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $\sqrt{0}$ Sevene Park MD Lois Jane Schramek 213 Newport De 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 28 2011 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 3:301 M 04-25 - 2011 Rosaria С. Moore /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 💢 F 82 **Director** 216-62-0697 July 10, 1928 Naples, Italy Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits at r 28a-f sh notified a 1 ☐ Yes 2 X No Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 2 must be n 21204 1 Smeton Place #1406 USA death Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed by 3 XWidowed 4 ☐ Divorced Item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental Pasquale Bruno Emilia Parente ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Tina DeFranco/Niece Baltimore, MD 21202 223 S. High St. 20b. Place of Disposition (Name of cemetery, cramatory or other place)
Dulaney Valley 20a. Method of Disposition 20c. Location - City or Town, State April 28, permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Timonium, MD Memorial Gardens 21. Signature of Funeral Service Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 ichael Flagle | e, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Parts. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final **Physician** Vetastat. disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, from Land Land Land Land Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Physician/Medical Examine physician and the burial-trans Division or Vital Records, P.O. Box $68760_{ ilde{\mathcal{C}}}$ Due to (or as a consequence of): physician as use a IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No 24a. Was an autopsy performed? 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier l-🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0054424 4-25-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cyrus Asadi, 3229 Dundalk Aue, Dundulk, MD 21222 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 28 2011 Registrar

DHMH 17 Rev 1/2001

11-03051 Laurie Marie Mc	Clun	Please Type	or Print in B e of Maryland	lack Inde	elible Ir	nk. En	sure Al	I I Copie ental Hy	s Are Leç	gible.	1 13596		
Laurie Marie Mc		I- For State			cate of				Re	g. No.			
Physicia Medical Exami	an/	Decedent's Name (First, Middle, Laurie Marie M							 Date of Deat Month April 21, 2 		3. Time of Death 1859 hrs		
		4a. Facility Name (if not institution, g)		4b. City, To		ion of Death	<u> </u>	4c. County of D	Death		
Funeral		Howard County General 5. Social Security Number 6.		ge (In yrs. last t	oirthday)	If Under	1 Year If t	Under 24Hrs.		th (MM/DD/YYYY)	J. Birthplace (State or		
Director		218-84-4466	_м 2₩,	37	Yrs	Months	Days H	ours Min.	01/03	/19/4	oreign Country) MD		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov			<u> </u>				10d. Inside City Limits		
	ē	MD Howard	·	Ellico	ott Ci						1 Yes 2 XXNo		
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 3992 College Ave	•			10f. Zip 0 2104	.3			og. Citizen of What USA			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	1 Yes 2 ed If Yes, Give Year		If Y	es, specify	t of Hispanic Cuban, Mex X No s <i>pe</i>	ican, Puerto	ecify Yes or No Rican, etc.)	White, e	American Indian, Black, etc. Vhite		
hours a	ted by	15. Decedent's Education (Specify Elementary/Secondary (0-12)	or Dates: only highest grade co College (1-4 or	, ,				Give kind of w NOT use retir		16b. Kind of Busin			
036 tthin 72 ne.	Completed	12	College (14 or		Custo	mer S	Servic			RETAII			
215-0	Be Co	William Morgan McClung 3rd Susan Parkent											
ID 21; should to and Men 77 is mar	2												
ore, N es 1 and 2 of Health If item 2		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S				e of cemeter		Date 27/2011	20c. Location - C	ity or Town, State		
Saltimos Pagranti. Pagranti progrant:		4 Donation 5 Other Spec. 21. Signature of Funeral Service Lice	ensee	M01452							Service, PA 21227		
Physician	-	23a. Part I. Enter the Isease, or col	mplications that cause								Approximate Interval		
/Medical			a. Pneumonia								Between Onset and Death		
		or condition resulting in death)	Due to (or as a cons b.	sequence of):									
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	sequence of):									
cuted and transit	ШĬ	d.											
e executi cian and irial - trai	dical												
Division of Vital Records, P.O. Box 68760, note Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours infer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	ome of pregnan	2 🔲 Fe	tal death		ctopic pregna	ncy	23d. Date of de Month	Day Year		
. BO) he death y the att	hys	1 Yes 2 No 9 Unkno	9 Olikilowii	ith but not resu	Iting in the s	underlying (cause given	in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?		
P.O es that to signed by	þ	, art ii. Outer significant correction		ar bat not room					1 Yes	s 2 No 3	Probably 4 Unknown		
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by uneral director, page 2 should be detach	Completed			·•·-					24a. Was autop perfo	pried? pried? de:	ere autopsy findings available or to completion of cause of ath?		
l Re(n: The tificate or, page	e Con	25. Was case referred to medical	1			2	6.Place of D	eath (Check	1 Yes	2 No 1	Yes 2 No		
Vita hysicia this cer	To Be	examiner? 1 ✓ Yes 2 No		ient 2 🗸 EF				7			Other:		
on of Nading Phyllith Ith r: After ti		27. Manner of Death 1 X Natural 5 Pending			b. Time of	Injury 2	8c, Injury at \	_	28d. Describe	how injury occurred	•		
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the and the death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Certification:	2 Accident Investig 3 Suicide 6 Could n determi	not be 28e. Place of	Injury - At home	e, farm, stre	et, factory,	office buildin	ng, etc.	28f. Location (or Town, S		or Rural Route Number, City		
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	4 Homicide 29a. Certifier 1 Certifying Physical Examination Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	sician: To the best of r	amination and/	death occu or investiga	rred at the tion, in my	time, date ar opinion, dea	nd place, and th occurred a	due to the caus t the time, date	se(s) and manner a and place, and due	s stated. e to the cause(s)		
To To Com	Med	29b Signature and title of certifier	and manner stated	1.			License nur	nber		29d. Date signed	(Month, Day, Year)		
		30 N me and address of person wi	no completed cause of	death (Item 22	a)		O.C.M.E.			April 22, 201			
		The and address of heison M	Jopiotou odubo oi		/								

Registrar

State 31. Date filed (Month, Day, Year)
sistrar APR 2 8 2011

ORIGINAL

Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 AM Physician/ APRIL Year MILTON 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SECOURS IMORE HUSP If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, **Funeral** (Month, Day, Ye Months Hours Min 1 ☑ M 2 □ F **Director** lam Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits event, the Medical Examiner must be notified at Director NIA 1 Yes 2 No 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ō 1 Newer Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", 3 ₩idowed 4 Divorced lack 15. Decedent's Education -(Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked can july or other traumatic eve once. ည 10 la ween 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1168 Somerville 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 292011 21. Signature of Funeral Service Licenses 2-70 4. mal 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death h sician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine as a consequence of) the burial-transit and Due to (or as nsequence of) attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 as IF FEMALE signed by the attendir d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No OBa within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of De th 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 28b. Time of 28c. Injury at work? 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29d, Date signed (Month, Day, Year) 170 un 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2<u>011</u> Physician/ Month Donna Μ Penyak April 17 2107 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Day Year Months Days (Month, I April 1 □ M 2 屎 F Hours 288-48-6473 58 $\stackrel{{\scriptscriptstyle {\it Country}})}{{
m Ohio}}$ Director 1952 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director MD 28a-f Rockville Montgomery 1 X Yes 2 No 10e. Street and Number ms 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 12250 Wilkins Avenue 20852 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Yes 2X No Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Freelance Writer & News Person Television 5+ other ulth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Penyak Sophie Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Don Caster - Cousin 9072 Moore Place North Dublin, OH 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4-25-2011 Alexandria, VA 21. Signatur 4 Donation 5 Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Formet, Clevenger & Gordon FH 1803 Cleveland Ave NW Canton, OH 44709 Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 24a. Was an

Physician/ **Examiner**

Baltimore, Maryland 21215-0036

within 24 hours are death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I

Division of Vital Records, P.O. Box 687

To the Hospital or Attending Physician: The within 24 hours at er death.

To the Funeral Director: After this certificate it

Completed Be မ Certificate:

Medical

25. Was case referred to medical

2 No

5 Pending

Investigation 6 Could not be

determined

1 Yes

27. Manner of Death

Natural

2 Accident
3 Suicide
4 Homicide

24b. Were autopsy findings available prior to completion of cause of autopsy

death?

April 17, 2011

performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 🗌 No

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

D31027

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road Bethesda, MD 20814 Paul OBrien, MD

State Registrar 31. Date filed (Month, Day, Year) 32.

28a. Date of injury (Month, Day, Year)

nv

28b. Time of

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 24 20^{Yea} George W. Patten. Sr. 2:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Genesis Heritage Meridian Ctr. Dundalk 8. Date of Birth (Month, Day, Yea April 10, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🙀 M 2 🗆 F Maryland **Director** 99 215-05-4135 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 XNo MD Baltimore City N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be Funeral 23a 1213 Anglesea Street United States 21224 items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates. WWII traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Yellow Cab Company Supervisor 11 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nellie Anton Walter W. Patten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codal 7871 Charlesmont Road Dundalk, Maryland 21222 Shirley Wright (Daughter) 1 and 2 s of Health of item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1XXBurial 2 Cremation 3 Removal from State Baltimore, Maryland 4/28/2011 Parkwood Cemetery 4 Donation 5 Other (Specify) Service Licensee 22 Name and Address of Facility al Home of Dundalk, Inc. Signature of F 7922 Wise Ave. Dundalk, Maryland 21222 Post + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE HFART Ph_sician/ Medical o (or as a consequence of) Examiner TNEMIA Sequentially list conditions. if any, leading to immediate cause. Liter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami ICIDNEY DISEASE HRONIC Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last RIPHERAL VASCULAR DISEASE Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown a Unknown s been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' nis certificate hi I director, page 1 🗌 Yes 2 🗷 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death eck only one) Be Hospital: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the KTulke M.D. ho completed cause of death (Item 23a) (Type, Print) Place Dundalk MD 21222 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 282011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2011 Fred Pinnix Leroy 12:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns Hopkins Bayview Medical Ctr. Baltimore City N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ Months April 25, Director 238-14-6166 95 North Carolina 1915 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Baltimore Edgemere MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7224 Waldman Avenue 21219 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 □ No If Yes, Give Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3₺ Widowed 4 Divorced Completed White Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Steel Industry 5 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Sparks Banner Pinnix 19a. Informant's Name/Relationship (Type, Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21219 7224 Waldman Ave. Edgemere, Maryland Mabel P. Smith (Daughter) Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 🔯 Burial 2 🗌 Cremation 3 🔲 Removal from State Cem. [23/2011 Meadowridge Mem. Park Elkridge, Maryland 4 Qonation 5 Q Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland

Baltimore, Maryland 21215-0036

			23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the snock, or heart failure. List only one cause on each line. Immediate Cause (Final		Interval Between
	Ph∫sician/ Medical		disease or condition resulting in death) As piration due to find the properties of	ood bolus in air	TWO V
	Examined sician and purial-transit	by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	f	CEMIEICATION APPROVED BY MEDICAL EXAMINER
68760	icate j phys is the	ledi	- a		CERTIFICA
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	nysician/N		opic pregnancy er (specify)	23d. Date of delivery Month Day Year
ls, P.O.	uires that the signed by the deta	ed by Pi	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown
Division of Vital Records,	Attending Physician: The law requires that the stroath. sctor: After this certificate has been signed by the funeral director, page 2 should be detached.	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No
70	ian: artific ctor,		25. Was case referred to medical examiner?	26. Place of Death (Check	
Ξ	nysic ilis ce idire	P	1 ☐ Yes 2 ☐ No Hospital:	☐ DOA Other: 4 ☐ Nursing Hor	ne 5 Residence 6 Other (Specify)
ou of	ending Pl eath. or: After the	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation 28a. Date of injury (Month, Day, Year) April 20, 2011 11:30AM	28c. Injury at work?	8d. Describe how injury occurred eating an orange
Divisi	tal or Att rs after de al Directe ed in by t	Certi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify) Home	actory, office	Ref. Location (Street and Namber of Rural Route Number of City or Town, State) Edgemere, Marvland 21219
	he Hospi in 24 hou he Funer ipleted fill	Medical	29a. Certifier (Check only one) 1	n, in my opinion, death occurred at t	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) and manner stated.
	10 With TO PO		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1) m/n	D-0061115	April 21, 2011
V	í		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Johns Hopkins I	Bayview Medical Ctr.
2+	1		Hardin Pantle, M.D.	4940 Eastern Av	ve. Baltimore, MD 21224
/ DHY	Sta Registr	ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 8 2011 Sum S. Sares		
DITIV	III I I Nev 1/2	oos	ORIGINAL		
			ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2^{Day} 23 04 5:30p.M Phillips 2011 Linda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2609 Pennsylvania Ave Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In yrs. last birthday) Hours (Month, Day, O 26 1 □ M 2 🛛 F Min. **Director** 55 21**7-**74**-**7186 GA Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 XYes 2 ☐ No MD Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21217 U.S.A. 2609 Pennsylvania Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Completed by 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
12th grade College (1-4 or 5+) Disabled Disabled na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Freddie Green Phillips Sr. Maryetta Aldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21217 Pennsylvania Ave, Baltimore, <u>Gordon Boone-Guardian</u> 2609 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/29/2011 Arbutus, Arbutus Memorial 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Funeral Service License Baltimore, 21215 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inmediate Cause (Findisease or condition mediate Cause (Final Onset and Death Physician/ -ancer 1/11 Medical resulting in death) Due to (or as a consequence of Examiner Can Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) Director: After this I in by the funeral dii 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Netural injury work? 5 Pending 1 🗌 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Scrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific CRNA 29d. Date signed (Month. Day, Year)

State

DHMH 17 Rev 7/2009

Registrar

9

No

21020

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

We-

32. Registrar's Signature

Ce

0

Augustina

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** A M April 26, 2011 6:00 Ruth E. Powell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Sykesville Fairhaven If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 2/5/1923 Director 88 Pennsylvania 219-18-8995 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examina. Trust be notified at 1 ☐ Yes 2 No Director MD Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 7200 Third Ave. Apt. A304 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) File Clerk Social Security 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Rachael Clark Ezra Elton Conner ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau once. Son 11003 Doxberry Circle Woodstock, Md. 21163 George L. Powell Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Bairrittore to Crettar cory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland @ Loudon Park 4/28/11 permit. 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave. Baltimore, Maryland 21229 -un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Physician ere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be activated to the cause of the cause Due to (or as a consequence of): Examiner sician and burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗀 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> icate has been siç r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes After this certifics funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: The To the Hospital or Attending within 24 hours after death.
To the Funeral Director After completely filled in by

3altimore, Maryland 21215-0036

Medical

Registrar

29b. Signature and title of certifier

29a. Certifier

(Check only one)

and manner stated.

factifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

address of person who completed cause of death Rd Eldersburg MD 21784

John Roger-Keith Preston

		1- For State Registrar		Ce	rtificat	e of D	eath				Reg. No	o.			
Physici		Decedent's Name (First, Midd	ile,Last)						2	Date of De	eath			3. Time of Dea	ath
Medical Exami	ner	John Roger 1	Keith Dr	acton						Month April 22,	Day 2011	Yea		1627 hrs	,
		4a. Facility Name (if not institution	on, give street and nu	ımber)		4b.	City, Town,	or Location	of Death		- 4	tc. County c	f Death		
		114 Northway Drive					łavre de	Grace				Harford			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda	ay) i	f Under 1 Y	ear If Und	er 24Hrs.	B. Date of I	Birth (MN	M/DD/YYYY		hplace (State o)r
Director		219-66-6672	XX _{M 2} F	53		Yrs.	Months D	ays Hour	s Min.	11/1	6/1	957	Foreig	n antry) MD	
		Usual Residence of Decedent	1 TC_ W1 2 F			115.									
any													10d. Inside Cit	ty Limits	
. ≸														1 Yes 2	
yland -f sh	ţ	MD Harf	ora	нач	re c						40 0	11 6 140-	10		
Mary r 28a	Director	10e. Street and Number	D				of. Zip Code 21078				US	itizen of Wh	at Coun	try?	
215-0036 be filed within 72 hours after death with the Maryland mat Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	ቯ	114 Northwa	y Drive				21076) 			US	n.			
n wid	Funeral	11. Marital Status		edent Ever in U	l.S. 1:			Hispanic Ori an, Mexicar			10-	14. Race White		an Indian, Blac	ck,
death	ᆵ	1 Never Married 2 X	1 Yes	2X No		11 103,	specify our	ari, mexical	, 1 001010	rouri, cic.,					
after after ner	by	3 Widowed 4 Di	vorced If Yes, Give Yea or Dates:	ar .		1 Ye	s 2X I	No specify	:			Specify: V	vnı	ce	
36 thin 72 hours : te. than "natur: edical Exami		15. Decedent's Education (Spe		de completed)				oation (Give			16b.	. Kind of Bus	siness/Ir	ndustry	
72 h	Completed	Elementary/Secondary (0-12)	College (*	-4 or 5+)				ile. DO 1401	use retire	u)					
Seif in it is	립	12	0		Car	pen	ter				1 C	onsti	ruc	cion	
15-003 filed withi Hygiene. d other th	S	17. Father's Name (First, Middle	e, Last)					1B.Mothe	r's Name (l	First, Middle	, Maide	n Surname)			
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be	Roger Presto	n					Joa	n La	tka					
2 5 8 E 2	၉	19a. Informant's Name/Relations				_	•					City or Town			
ages I and 2 shount of Health and It. If item 27 is nother traumatic		Stanley Pres	ton / Br	other	1172	200	Wesle	∋y Ch	apel	Rd.	Mo	nkto	\mathbf{n} , \mathbf{M}	2111	1
e, ML 1 and 2 st Health au 1 item 27		20a. Method of Disposition					(Name of			Date		. Location -			
Baltimore, bermit. Pages I as Department of Her important: If ite		1 Burial 2 Crematio		om State	crematory	roromer;	is &	CO	4/26	/201	1 W	est (ine:	ster, ania	
tiner ritmer		4 Donation 5 Other S		110.	A. 1										_
Baltimo permit. Page Department (Important: injury or otl		13711	P.		- 1	Tar	ring	-Carg	o Fu	ınera	1 ч	ome, en, l	P.	A .	
	-	23a. Part I. Enter the disease, or	r complications that c	aused the death	Do not e	333	S.	Parke	St,	Abe	rae	en, I	dD .	21001 Approximate	Interval
Physician /Medical		failure, List only one cause		auseu ii la ueali	i. Do not e	11(01 (110 11	lode of dyli	y, such as t	Zardiac Or 1	espiratory a	11631, 31	lock, of field		Between On:	set end
Examiner Immediate Cause (Final disease a. Contact Shotgun Wound of Head													Death	1	
		or condition resulting in death)	Due to (or as a	consequence of	of):										
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b.	consequence of	·6.										
	Ë	cause Enter Underlying Cause		consequence c	, ,.										
	Examiner	(Disease or injury that initiated events resulting in death) Last		consequence o	of):										
outed nd ransi			d												
Records, P.O. Box 68760, m: The law requires that the death certificate be executed tificate has been signed by the attending physician and or, page 2 should be detached for use as the burial - transit	/Medical	UNPENDED	AMENDED												
760, ficate be g physic the bur	Š	IF FEMALE:	23c. If yes,	outcome of preg	inancy						2:	3d. Date of	delivery		
rtifica ing p	3	23b. Was decedent pregnant in t past 12 months?	he 1 Live b	irth	2	Fetal d	leath 3	Ectopi	c pregnanc	у		Month	D	ay Ye	ear
Box 68 e death certifi the attending ed for use as	<u>:</u>			ant at time of de	eath 5	Other	(Specify)				1				
, P.O. Box 68 res that the death certifusigned by the attending be detached for use as	Physician		a Clivin												
, P.O. res that the signed by be detach	by P	Part II. Other significant condi	tions contributing to	death but not r	esulting in	the unde	rlying cause	given in Pa	art I.					he cause of dea	
ires ti	D D									1 L Y	es 2	✓No 3	_ Prob	ably 4 Unl	Known
Records, The law require fificate has been si	Completed									24a. Wa	s an opsy			opsy findings a ompletion of car	
e law e has ge 2 sl	m d									per	ormed?	de	eath?		
tal Recition: The certificate rector, page		05 Wes					00 Di-		(0)	1 ✓ Yes	2	No 1	✓ Ye:	2	No
	B	25. Was case referred to medica examiner?	Allega Male		500			ce of Death Other			7	a [7	l 011		_
on of Vita ending Physicia ath. or: After this ce the funeral direct	입	1 Yes 2 No 27. Manner of Death		npatient 2	ER/Outpa			jury at Work				lence 6 ✓		Scene	
- ± . ^ द	崩	1 Netural	28a. Date FOUND	Day,Year)	FOUND	ne of Injury O	l		. le	ubject sh		njury occurre f	a		
ttend death	ä	Pen	ding estigation Apr 22,		1625 hi		1	Yes 2	No						-
Division tal or Attendi rs after death.	븳		la not be	e of Injury - At h	ome, farm,	, street, fa	ctory, office	building, e	tc. 2	Bf. Location or Town,		and Numbe	r or Rur	al Route Numb	er, City
Dital Durs 2	Certification:	4 Homicide	ermined (Specify)	At home					111	14 Northwa	y Driv	e, Havre d	e Grac	e, MD)
Hos 24 h		Chock only	hysician: To the bes		-			-							
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exa	aminer:On the basis of and manner s		nd/or inve	estigation,	in my opini	on, death oc	courred at t	he time, dat	e and p	lace, and du	e to the	cause(s)	
H 3 E 8	M	29b. Signature and title of certifi-					29c. Lice	nse number			29d	. Date signe	d (Mon	th, Day, Year)	
		my are	0				0.0	M.E.			Ар	ril 23, 20	11		
		30. Name and address of persor	who completed caus	se of death (Item	23a)										
Da			ant Medical Exar			imore S	Street, Ba	altimore,	MD 212	23					
	ate	31. Date filed (Month, Day, Year)		gistrar's Signate											
Regist		APR 2 8 2011	6	6 /											

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rancis Blake Pre		⊓ I- For State	Stat	e of Maryland		artment of rtificate of			ıaı nyç		20	Alenan	13604
Physicia		Registrar 1. Decedent's Name (F	irst, Middle,L	.ast)		- Inouto of	Bouin		2	Date of Deat	eg. No.		3. Time of Death
Medical Examin	-	Frances							i	Month April 22, 2	Day Yes 011	ar	1627 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Havre de Grace Harford										of Death	
		114 Northway			(1	and birth days)	If Under		er 24Hrs.	9 Date of Bir	th (MM/DD/YYY)	n a Rin	onlace (State or
Funeral Director		5. Social Security Num		Sex 7. A	50	ast birthday) Yrs	Months				1960	Foreign	
		218-92-48 Usual Residence of De		M ZAF	- 30	- 115	.				., ., .,	J	
k e			b. County		10c. City	Town or Locat	ion						10d. Inside City Limits
Maryland 28a-f show d at once.	ğĹ		Harfo	rd	Hav	vre de							1 Yes 2 No
or 28a-	Director	10e. Street and Number		D			10f. Zip 0]	0g. Citizen of W	nat Coun	try?
		114 Nort	nway	12. Was Deceder	nt Ever in U	.S. 13. Wa		78 t of Hispanic Orig	gin? (Spec	ify Yes or No		- Americ	can Indian, Black,
eath w	Funeral	1 Never Married	2 X Marr	Armed Forces				Cuban, Mexican,			Whit	e, etc.	
after de la	e F	3 Widowed	4 Divord	ced If Yes, Give Year or Dates:			_	No specify:			Specify:		
hours natur	8			only highest grade co				ccupation (Give ling life. DO NOT			16b. Kind of Bu	isiness/li	ndustry
36 uin 72 e. i. ihan "	Completed	Elementary/Second		College (1-4 o	(5+)	Homema	aker				At Ho	me	
d with	탉	17. Father's Name (Fi		t				18.Mother	's Name (F	irst, Middle, I	Maiden Surname)	·
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", ic event, the Medical Examiner.	Be	George P						Mary					
D 21 should and Me	ᅀ	19a. Informant's Name				- 15		(Street and Num					
and 2 sho ealth and traumati	-	Elizabet 20a. Method of Dispos		Wilson/S	20b.	Place of Dispos	ition (Name			Date	20c. Location	- City or	Town, State
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er				3 Removal from S		crematory or ot A。 Fer:		& Co.	4/26	5/2011	West Penns	Che vlv:	ster, ania
nit. Pa artmer ortan	ŀ	4 Donation 5 21. Signature of Fune						45 25	_				
B P P B		Dat 1	There	11/1/2		3	arrii 33 S	ng-Caro Parke	so Fi	inera. . Abei	deen.	MD.	21001
Physician		23a. Part I. Enter the c	isease, or co one cause or	mplications that cause each line.	d the death	. Do not enter t	he mode of	dying, such as ca	ardiac or r	espiratory arr	est, shock, or he	art	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Fir or condition resulting		Due to (or as a con								_	Death
		Sequentially list condi		b.	sequence	,,. 							
	필	if any, leading to immediate. Enter Underly	ediate	Due to (or as a cor	sequence o	of):							
	Examiner	(Disease or injury that events resulting in de-	millared	Due to (or as a cor	sequence o	of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	ᇎ			d									
O, e be ex sician burial	edical	UNPENDED		AMENDED							23d. Date o	deliven	
Sox 6876 leath certificate e attending phy for use as the 1		IF FEMALE: 23b. Was decedent pre- past 12 months?	egnant in the	23c. If yes, outo	ome of preg		tal death	3 Ectopic	c pregnanc	су	Month		ay Year
ath cer attendi	Physician/N		9 V Unkno	4 Pregnant 9 Unknown	et time of de	eath 5 Ot	her (Specia	fy)			di-		
C. B.	됩			ns contributing to de	ath but not i	resulting in the u	underlying o	cause given in Pa	art I.	23e. Did to	obacco use cont	ibute to	the cause of death?
res that signed l	출									1 Yes	s 2 🗸 No 3	Prob	ably 4 Unknown
of Vital Records, of Vital Records, by Physician: The law requirements of the this certificate has been a meral director, page 2 should be	Completed by									24a. Was autop			topsy findings available ompletion of cause of
eco he law ate has	E									perfo 1 Yes		death? ✓ Ye	s 2 No
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred examiner?	to medical	(4)-(3)31			26	6.Place of Death					
al dire	ટા	1 ✓ Yes 2	No		tient 2	ER/Outpatient					Residence 6 how injury occur		: Scene
/ 프로 . 약급		27. Manner of Death 1 Natural	D Pendin	28a. Date of Ir	njury ,Year)	28b. Time of t		Bc. Injury at Work 1 Yes 2 ✔	. Is	ubject sho		ieu	
Division tal or Attendi rs after death.	Certification:	2 Accident	Investig	gation Apr 22, 201		1625 hrs nome, farm, stre		office building, et				er or Ru	ral Route Number, City
Div	er E	3 Suicide 6 4 ✔ Homicide	Could to determ		t home				1.	or Town, S 14 Northway	State) / Drive, Havre	de Grad	e, MD
Hosp 24 ho		Torreck Gray	ertifying Phy	sician: To the best of	my knowled	ige, death occu	rred at the t	time, date and pla	ace, and d	ue to the caus	se(s) and manne	r as state	ed.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical			ner:On the basis of ex and manner state		aridror investiga		opinion, death oc License number	AUITEU at 1	me time, date	29d. Date sign		
	2	29b. Signature and tit	// /	UP			- I	O.C.M.E.			April 23, 2		, = =,, , ==,,
00	-	30 Name and address	s of person w	ho completed cause o	death (Iter	n 23a)							
A.	-	Ling Li, MD		Medical Examin			re Street	t, Baltimore, I	MD 212	23			
Sta	ate	31. Date filed (Month)	Day Year)	32. Regis	ar's Signat	ture Colo							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201 Theem Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Examiner UNIVERSITY OF MARYLAND MEDILATE BALTIMORS 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1**X** M 2 □ F n/a 4/22/1 Director MD Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD NIA 1X Yes 2 □ No 10g. Citizen of What Country? 10f, Zip Code 21229 1307 Wildwood Parkway - Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Amer 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry N/A Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rickey Carson Rogers Kemesha Belle Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kemesha B. Thomas/Mother 1307 Wildwood Pkwy-Apt.\$,Balt.,Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cromation 3 Removal from State
4 Donation 5 Donation 5 Other (Specify) 5/2/11 Baltimore,MD Bayview Crematory 22. Name and Address of FacilityHari P. Close F.S.PA 5126 Belair Rd, Balt., MD 21206 21. Signature of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HLDIORESPIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DAYS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? INTRAUTERINE GROWTH RESTRICTION 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available ACUTE CENAL 24a, Was an prior to completion of cause of death? autopsy performed? certificate ha irector, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 24 hours after death le Funeral Director: A bleted filled in by the fi 1 🗌 Yes 2 🔲 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I comple Certifying Nurse Practioners To the best of my knowledge, death per d at the time, date and place, and due to the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amelon, MO 11:50PM-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRESNE ST RM-GSILD. BALTIMORE NO, 21201 31. Date filed (Month, Day, Year) State APR 28 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 194 RODRIGUEZ ROMBROROMBRO 0720 BLIZABETH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SPRING CROS UZR RAMOUTGOMER HOI HOSPITA Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) Month, Day, Year, 1 M 2 M F Months Min. Director N M Usual Residence of Deceder 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No SILUER SPRING MONTGOMERY 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20904 BOURNE SA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Vyes 2 No Specify: EL SALVADOR 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry ould be filed within 12 in and Mental Hygiene.
is marked other than "r
is marked other then "r (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) TURTUI TURANI of Health and Mental Hygier of Health and Mental Hygier of item 27 is marked other it rother traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ည RODRIGUE ROMERO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY CROSS S. MD.20910 GLEN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state cemetery, crematory or other placel 21. Signature of Euneral Service Licens. State and Address of Facility and 655 W. Baltimore Street Director MD 23a. Patt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician EXTREME PREMAT Medical resulting in death) Due to (or as a consequence of) Examiner EPSIS Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last 3 hrs that the death certificate be executed 120G1 WETABOLIC and-trar Due to (or as a consequence of) burial-/sician Physician/Medical as the t phy attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires: within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: Other: 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D 28060 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KESSLER MARY LENORE MD 20910 1500 FOREST GLEN RD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 28

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Theresa M. Rosenkilde April 8 9:10 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Nursing Center Dunda1k Baltimore Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea an 13, 1 Country) Louisana Months Days Hours Min. 1 □ M 2 💢 F 439-38-4735 Jan Director 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2x No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 Center Place #218 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 3 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) distillery worker beverage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Anthony Putch Anna Jimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette A. Mannin/granddaughter 3218 McShane Way Baltimore, MD Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation—
Signature of Funeral Service Licensee
Ronald S Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Que to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying MONAR To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last DEMENTIA Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death i signed by the and to detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work?
1 \quad Yes 28d. Describe how injury occurred 5 Pending Natural 2 🗌 No Investigation Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

New Place Dundale MD

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ ellam awtord 2011 DVVI Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Loch Raven Community LIVING Cente Baltimore Baltimore If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Nov 29, Year 922 Months 1 🕅 M 2 🗆 F Virginia 219-16-9361 88 Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1050 E. 33rd Street #422 21218 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: black 3 Widowed 4X Divorced Year or Dates. 1943 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) truck driver transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Stratton Mollie Getting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21227 108 Circle Terrace Arbutus, MD Charles Neal/grandson 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signature Licensee and Sonal of S. Wad State and Address of Facility acids and 655 W. Baltimore Street rector Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Renal Interval Between Onset and Death Disease Immediate Cause (Final age Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an after death.

Director: After this certificate has be autopsy prior to completion of cause of death? 1 ☐ Yes 2 🗗 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Hospital: 6 Other (Specify) OSPICE ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Many r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 🗀 No Accident Investigation □ Accider

 □ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

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3900 Loch Ra Baltimore

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Mary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:00 P April 25, 2011 Smith Rosalie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Summit Park Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days May 16, ^{Country}Maryland Months Hours Min. 1927 **Director** 83 219-22-3771 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Catonsville MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 402 Bloomsbury USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Henry Rigby Catherine E. Finkner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 402 Bloomsbury Ave, Catonsville Maryland 21228 James Smith- Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel 🕅 Rurial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cathedral CemeteryApr. 28, 2011 Baltimore Maryland 22. Name and Address of Facility Ambrose Funeral Home Inc. Ineral Service Lice Sulphur Spring Road Arbutus Maryland 21227 1328 23a. Part 1. Enter the disease, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi Cause (Disease of linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ is certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 6 2011 of person who completed cause of death (Item 23a) (Type, Print) 1009 Fredrick

DHMH 17 Rev 7/2009

State Registrar My

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:51 PM APTIL 26 2011 TOFACE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5-4-) Birthplace (State or Foreign Country) **Funeral** 220-52-267 60 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at an once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 ☐ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 21213 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Worker lops lemporar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Frank Stokes E. Mello Corine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stokes Baltimore, MO 2/2/3 Andrew Broadway 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5-3-2011 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Service Lic. 1101 E. North Ares Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Day 5 Other (specify) Yes 2 No should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 No 1 TYes 2 🗌 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 1 🗌 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Natural 2 Accident s after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 🗌 Homicide City or Town, State) fo the hc.
within 24 hours
To the Funeral D' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

andice 31. Date filed (Month. Dav. Year) State APR 28 Registrar

Nomisse 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 10:30M IANNA BARTELAK SIMMONS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10247 Green Holly Terace Silver Spring Montgomery Co. 8. Date of Birth 2-16-1930 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday Funeral Days Poland Months Hours 81 Director 578-72-6288 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director MD 1 Yes 2 V No Silver Spring Montgomery Co 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 USA 10247 Green Holly Terace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White of Health and Mental Hygiene. Hem 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales 12 Credit <u>Manager</u> N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Piotr Bartelak Dudek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is 7219 Black Creek Ln. Frederick, MD 21703 Krzysztof Szymonik-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 Burial 2 A Cremation 3 Removal from State Bayview Crematory 4-29-2011 Baltimore, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ NDSTAGE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner HYPER Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner RULD ALEPITRITIS the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 4 Pregnant a been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No has page 2 this certificate : After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours feer death.

To the Funeral Lirector: Af completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spring, Silver MD 12201 Plum Orchard Drive Daquioag, M.D. Eleanor 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	Pleas	e Type or Pr State of M		id / Dep		Health an	e All Copie d Mental Hy		egible.	13512
Physicia Medic		1. Decedent's Name Rubin	e (First, Middle, L	^{ast)} Samu	els				2. Date of De Month April	ath Day	Year 2011	3. Time of Death
Examin		4a. Facility Name (if		ve street and number)			4b. City, Town,	or Location of D	eath		ounty of Death	
Funeral Director		5. Social Security No. 220 – 05 – 9	umber 9132 6.		ge (In yrs. I 91	ast birthday) Yrs.	If Under 1 Yea Months Days		Hrs. 8. Date of Bir Min. (Month, Da Mar 10	y, Year)	Cou	nplace (State or Foreign intry) cyland
aryland a-f show ified at	Director	Usual Residence of 10a. State Md •	10b. County			y, Town or Lo	ocation City	<u> </u>		-		10d. Inside City Limits 1
with the M 23a or 28 ist be noti		10e. Street and Nur 427 Nort		Avenue			10f. Zip Code 212				n of What Cou	untry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "naturaly", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 □ Never Marr 3 □ Widowed	ied 2 ☐ Married	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates.	?		Was Decedent of If Yes, specify Cui	oan, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		. Race - Amer Black, White ecify:	
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it. Page 1 a		4 Donation	☐ Cremation 3 5 ☐ Other (Spe		e	cemetery, cre rrisc		stVA	pr 1 ^{ate} 28,2011	Owin;		lls, Md.
permit Depar Impor any in		21. Signature of Fu	8 VM	mplications that cause	ad the deet	1	201 Du	ndalk .	Avenue B	alti		1 Home, PA Md. 21222
hysician/ Medical Examiner		shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List onl (Final	one cause on each li	ne.		ncer			efem	ed	Interval Between Onset and Death
ann cermicate be executed attending physician and for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
To the Hospital or Attending Prysician: The law requires that the death certificate be executed within 24 heart death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medic	1 Live Birth 2 Fetal death 3 Ectopic pregnancy									d. Date of deli Month	ivery Day Year
ulres tnat tr n signed by ald be deta	ed by P			contributing to death				given in Part I.				the cause of death? robably 4 🛂 Unknown
ine law req ate has bee page 2 shoi	Completed by										prior to death?	topsy findings available completion of cause of
sician: certifica irector, I	Be	25. Was case referr examiner?	ed to medical	Hospital:		LED/O 111-		ther:	Check only one)] 041(0	SE 1
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tal or Atter rs after dea al Director ed in by th	al Certificate:	3 Suicide 4 Homicide	6 Could no determine	28e. Place of Ir	njury - At ho tc. <i>(Specif</i>		reet, factory, offic	9	28f. Location (City or To		lumber or Rur	ral Route Number,
the Hospi thin 24 hou the Funerampleted fills	Medical	(Check 2 only one) 3	Medical Exa	hysician: To the best ominer: On the basis of urse Practioner: To the	examinatio	n and/or inve	stigation, in my opi death occurred at	nion, death occu the time, date ar	rred at the time, date	and place, ar ne cause(s) a	nd due to the o and manner as	cause(s) and manner state stated.
S D wit		29b. Signature and	.t. I	lub, m		00.1.7	D	21464			signed (Month $1\ 27$,	
1			ert T.	Liberto,		3508		Street	Baltimo	re, l	Md. 2	1224
Stat Registra			ADD 9 8		. a. s orgila	1 %	0. 1. 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 19 pay 3:17P 2011 James W. Small Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N. Woodington Road Baltimore 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Carolina 251-62-3644 1 🕱 M 2 🗆 F Months Hours Min Yrs **Director** 30-1940 Usual Residence of Decedent 28a-f show 10c. City, Town or Location
Baltimore permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanium. 10a. State 10d. Inside City Limits 10b. County **Funeral Director** MD 1 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 2 N. Woodington Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🛛 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Bethel Steel 4th Be 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) ပ Eli Small 19a. Informant's Name/Relationship (Type, Printaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1268 Walker Ave. Balto, MD 21239 Jackie Washington 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD Ardent Crem. 22. Name and Address of FaciliPhillip A Weatherfordfs PA 21. Signature of Funeral Service bicensee E oliver St Balto. MD 21213 2431 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the should be detached g Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s 1 Yes 2 No this certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral I 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier mpleted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 17 PM Timothy C. Thomas 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICO HOSPICE ATTHE JBUR If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Apr I 9 ay, Min. 1 🛛 M 2 🗆 F Months Days Hours Mary Land 71 ¶939 Director 214-36-5625 Usual Residence of Decedent ishow 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location with the Maryland Director 10d. Inside City Limits or 28a-f 1 🗆 Yes 2 😾 No MD Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 448 Charlotte Avenue 21817 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white "natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M ones. College (1-4 or 5+) crabber seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Bradley Thomas Dorothy Virginia Carey 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Poole/sister 26693 Old State Road Crisfield, MD 21817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 □ Donation 5 🗓 Other (Specify) in state Signals of Fyneral Sovice Licensus 28 Hareard Address of They lit Board 655 W. Baltimore Street Director Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CAKDIOVAS CULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the aid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No ျပ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work?
1 Yes 2 No 5 Pending injury Investigation M within 24 hours after deati To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHARE DA,

DHMH 17 Rev 7/2009

State

Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Stephen Edward Thaxton Apri1 1:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel <u>1117 Paca Drive</u> Edgewater 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y June 20 Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Y^{ear)} 1<u>950</u> Months Country) DC 1 ★ M 2 □ F Hours **Director** 213-58-7592 60 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** or 28a-f 1 ☐ Yes 2 🔀 No Edgewater <u>Maryland</u> <u>Anne Arundel</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a be filed within 72 hours after death with 1117 Paca Drive 21037 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Completed by Black, White, etc. ò 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: "natural", 3
Widowed 4 Divorced If Yes, Give Specify White Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur iury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hair Salon Hairstylist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jane Drury <u>Wilber</u> James Thaxton Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Paca Drive, Edgewater, Maryland 21037 Judith M. Thaxton / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Metro Crematory Inc. 04/27/2011 |Baltimore, Maryland 21. Signature of Funeral Service Licensee $Alyson\ K$ Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Physician/ LIGISASTOM disease or condition Medical resulting in death) Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed y 1 Yes 2 No Yes Be 25. Was case referred to nedical 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natura 5 Pending iniun work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signa 24169 4-27-2011

Registrar

DHMH 17 Rev 7/2009

State

Dr. Stephen C. Hamilton, 116 Defense Hwy (Ste. 400), Annapolis, Maryland 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

APR 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Physician/ 12:42 PM TAMBERIND GUY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITA Corumsia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. October 15. Hours 1 X M 2 □ F Months 1939 Mary Land 212-36-6509 **Director** Usual Residence of Decedent show. 10d Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0a. State 10b. County Director Baltimore Maryland Timonium 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 111 Gorsuch Road 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12, Was Decedent Ever in U.S Armed Forces Black White, etc. ģ 1 Never Married 2X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)

Comptroller (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anthony Tamberino Angela Gamberdella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dawn L. Tamberino/Wife 111 Gorsuch Road Timonium Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Dulaney Valley Mem. Gardens 4/29/11 Timonium Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Flacilly E007a Td J. Ruck Inc. 5305 Harford Road Baltimore Maryland 21214 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician AWTZ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner IWEK PNEWMONTA BAUTERIA Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day 2 No 1 Yes 2 L been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AWTE CEREBROWS WIND MICHENT 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? PARKINSONS DISTASZ 24a. Was an autopsy performed? has FAIWRE CHRONIC RENTE 1 ☐ Yes 1 Yes 2 No 2 046 certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 I ER/Outpatient 3 I DOA Certificate: To After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation after death Director; / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination allows introduced at the time, date and place, and due to the cause(s) and manner as stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 036974 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4-310 Corumsia O. NYANIOM MD. 10710 CHARTER DRIVE mo 21544 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 28 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g914 4-28-11 yt State of Maryland / Department of Health and Mental Hygiene 2 13617 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 9 Tracy Agnes D. Μ 6:41 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Social Security Number 256 20 0384 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Georgia ecurity Number 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** (Month, Day, Sept 23, 1 □ M 2 XX Months **Director** 91 Usual Residence of Decedent or 28a-f shov 10a State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Directo** 1 Yes 2 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9316 Pineview Lane United States 20735 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify: White 3XX Widowed 4 Divorced Year or Dates. ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Brewer Lolra Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lynn G. Tracy (Son) 37999 Mount Wolf Road, Charlotte Hall, MD 20622 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) unk Arlington National Cemetery Arlington, Virginia 21. Signature of Funeral School in Insee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1012613 Immediate Cause (Final Onset and Death DOUNKE Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death cate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 💆 No Hospital: Other: ၉ 1 S Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🐔 Natural injury 5 Pending work?
1 Yes 2 No 2 🔲 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year) State

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC MCDONALD, M.D.

32. Redistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D 6 40 5.5

URRATIS ROAD CLANTON MD 2013,

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

Registrar

7503

State Registrar

Landoner

DHMH 17 Rev 1/2001

ORIGINAL

am

32. Registrar's Signature

MD 2123 (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8813 Walk

Tigan

n, Day, Year)

31. Date filed (Mont

Physic /Med Exami **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If Medical Exactions in the confident once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		nt of Heal te of Dea		nd Me		ene g. No?	E CONTRACTOR DE	1351
Decedent's Name (First, Middle, La	st)					2	. Date of Death	1 1	1 4	3. Time of Death
Chiwless App He						Δ	Month pril 11	Day 2011	Year	5:30 PM
Shirley Ann Wa 4a. Facility Name (If not institution, give			4b. City,	Town, or Loca	tion of E		prar i	4c. County		
3129 Kaetzel R			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Gap1				Was	hing	ton
5. Social Security Number 6. S		je (In yrs. last birthda)	/) If Under	1 Year If U	nder 24	Hrs. 8	. Date of Birth	, ,	9. Birth	place (State or Fore
220-42-1630	I□M 2XF	65 Yrs.	Months	Days Ho	urs I	Min. J	Date of Birth (Month, Day, uly 12	1945	Mar	yland
Usual Residence of Decedent										
10a. State 10b. County		10c. City, Town or I	_ocation							10d. Inside City Lim
MD Washin	gton	Gap	land							1 □ Yes 2▼ I
10e. Street and Number	-		10f. Zip	Code			10	g. Citizen of V		intry?
3129 Kaetzel Ro	ad			21	779			U	ISA	
11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Dece	dent of Hispani cify Cuban, Me	ic Origin	? (Speci	ty Yes or No-		e - Amer	ican Indian,
1 ☐ Never Married 2 ☐ Married	1 ∏Yes 2 📉	No	1 □Yes		ecify:	dorto (in	our, o.o.,	Specify	1	nite
3 ☐ Widowed 4 X Divorced	Year or Dates:		12100	2 <u>11</u> 110 Op	oony.			Specify	, ···	4-1
15. Decedent's E (Specify only highest gro	ducation ade completed)			al Occupation ork done during	most of	working		6b. Kind of Bu	usiness/Ir	ndustry
Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT u	se retired)				HQ Q		4
12				1			5000 1500 10	US Gor		ent
17. Father's Name (First, Middle, Last				18. 1		,	First, Middle, M Amelia		ie)	
Wayne Melvin Sr		1	y	(2)					O4 : =	- O-da'
19a. Informant's Name/Relationship Jerry Wade/form							Route Number, Land, M			ip Code)
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Speci		20b. Place of Disp cemetery, cr	oosition (Nai ematory or d	me of other place)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Dat	e 2	Oc. Location -	City or T	own, State
21. Signature of Funeral Service Lice	Wade, Dir	/		nd Address of P Anatomy ore. MD		ard (655 W.	Baltim	ore	Street
shock, or heart failure. List only Immediate Cabe (Final disease or condition resulting in death)	a. 0	a consequence of):	Conc	Cy						Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	⊟ Ectopic p □ Other (s _j						te of deli	very Day Year
Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying o	cause given in I	Part I.			acco use cont		the cause of death?
						_	24a. Was an autopsy perform	red? /	death?	topsy findings availa completion of cause 2 No
25. Was case referred to medical examiner?				26.	Place of	Death (Check only one			
1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpati	ent 3 🗆 Do	OA Other: 4	☐ Nursi	ing Home	5 Reside	nce 6 🗆 Oth	ner (Spec	cify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		ary 28b. Time ay, Year) Injury	of 2	28c. Injury at Work? 1 ☐ Yes		28	d. Describe ho			
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Ini	ury - At home, farm, s c. (Specify)	street, factor	y, office		28	f. Location (Str City or Town	eet and Numb State)	er or Ru	ral Route Number,
29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	hyslcian: To the best miner: On the basis o and manner st	of examination and/or	ath occurred investigation	at the time, dans, in my opinion	ate and n, death	place, ar occurred	d due to the ca	ause(s) and mate and place,	anner as and due	stated. to the cause(s)
29b. Signature and title of certifier			29	c. License num	nber		29	d. Date signe	ed (Month	n, Day, Year)
Michael	Mulow	I MI)	04	160	. 7		4.	18	.11
30. Name and address of person who	completed cause of c	death (Item 23a) (Type Mccl/ rar's Signature	e, Print)	0 10	he.	Are	c1 (maus	Be	ico hun
31. Date filed (Month, Day, Year)	37 Registr	rar's Signature	- 41		-					,

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DHMH 17 Rev 1/2001

Sta Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10c per fh 9912 4-28-11 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ 2357 Williams Mary 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore cf medical Center Maryland If Under 1 Year If Under 24 Hrs. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Min 1 M 2 X Yrs MD Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland aţ 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Baltimore MD 21207 1 Yes 2 No **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hill Funeral Blue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Macvis Sales Uerk 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, John Andrew timelia Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimure MD 21244 Demetriou Cambenvell Court Daughter avna 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Garrison Owings Mills, MD 21. Signature of Funeral Service Licenses C. Greene Fundral Service 22. Name and Address of Facility Vaughn Vana ibert 28 odd Randallstown MD 21172 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Caus (Final Onset and Death Ph.sician/ Secticemia disease or condition Medical resulting in death) Due in (or as a consequence of): Examiner eukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or imput that initiated events resulting in death) Last physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending proposed should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Natural 5 \square Pending Accident 2 No 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) EW MD 110414166) April 26 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Bultimore 312016 3.3 IND Bryan Moore 31. Date filed (Month, Day, Year) 3. Registrar's Signature State 28 PR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 Westendorf Stanley Francis 2011 7:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Elm Twin Court Linthicum Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Days 1**XX**M 2 □ I Months (Month, Day, Year) 12/02/1939 518-42-7062 **Director** 71 Idaho Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Anne Arundel Linthicum Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 U.S.A. 440 Elm Twin Court 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No 1 Never Married 2 Married ģ X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes. Give White 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Hardware Engineer 4 it. Page 1 and 2 should be filled wi rtment of Health and Mental Hygir rtant: If item 27 is marked other njury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Westendorf Trene Kathryn Ehlers William Kurt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linthicum Heights, MD 21090 Mrs. Elizabeth Westendorf/ Wife 440 Elm Twin Court 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/30/2011 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Examin Cause (Disease or linjury that initiated events the burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? detached for Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed. Yes 2 No death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 🗆 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying-Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101/ Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frederick Wassman 0 Apr 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital <u> Howard</u> Columbia If Under 9. Birthplace (State or Foreign Country) Maryland **Funeral** . Age (In yrs. last birthday, Year If Under 24 Hrs 8. Date of Birth 1 XM 2 - F Months Hours Days (Month, Day, Year) 2/9/1925 213-20-5785 Director 86 Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral er than "natural", or items 23 the Medical Examiner must 421 Oak Court 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. þ 1 Never Married 2 M Married 1 ★ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. WW II White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I and Mental Hygiene. **7 is marked other than "r** Elementary/Seconday (0-12) College (1-4 or 5+) Steamfitter Lloyd E. Mitchell Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Frederick Wassmann Margaret Poe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Wife Mrs. Beatrice Wassmann Oak Court Catonsville, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🖵 Removal from State 4 🗆 Donation 5 🗷 Other (Specify) tombunet Loudon Park Cemetery: 4/29/11 Baltimore, Maryland Signature of Funeral Service Linnsee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enjer the disease, or shock, or heart failure. List of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ly one cause on each line Immediate Cause (Final intection Ph sician/ urinary Walt disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death.

Director: Aff 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) NO0 66515 M.D 2011 23 whi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature APR 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Time of Death Month Day April 21, 2011 **Medical Examiner** MICHAEL YELLALONIS 1034 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1603 Burnfield Road Rosedale **Baltimore County** 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country Director 212-70-9945 Months Days Hours 46 1 X M 2 F 4-30-1964 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygene.
ant: If item 27 is marked other than "antural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. MD BALTIMORE 1 Yes 2 X No ROSEDALE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 BURNFIELD ROAD 21237 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: WHITE <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 2 MAINTENANCE BWI 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEONARD YELLALONIS Be LILLIAN CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILLIAN YELLALONIS / MOTHER 1603 BURNFIELD ROAD ROSEDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) METRO CREMATORY 4-27-11 CATONSVILLE, Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME T211 CHESACO AVE 21237 ROSEDALE, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Medical Mixed Drug (Cocaine, Methadone, Heroin) Intoxication Death xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a, 27, 28a-f per me g915 5-9-11 vt the attending physician ed for use as the burial -X UNPENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other Scene this 2 No 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Pending 1 Yes 2 X No Director: fd 4-21-11 fd 10:30am unknown Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State) 1603 Burnfield Rd. determined residence Rosedale. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 22, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year APR 28 g trar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Records, P.O. Box 68760,

Division of Vital

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

\(\) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Cleda Gay Ayers/Fisher 2011 6:10 P M 07 Apri] Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Caroline Caroline Nursing Home Denton 8. Date of Birth (Month, Day, Year)
March 25, 1924 West Virginia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Months Days Hours 87 Director 236-28-9204 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Denton Caroline MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Funeral 21629 520 Kerr Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Companies Clerical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Should be file and Mental Pris marked o ပ္ Flora B. Walker John W. Hunnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 626 Liberty Road, Federalsburg, MD 21632 David W. Ayers/Son I and 2 s F Health permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Federalsburg, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/11/11 Hill Crest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ advanced disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death 1 Yes 2 4 9 Unknown eral Director; After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached t g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Com 200233252 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 reston MD ~K R 2 But 3683 - 49 av. 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Bill Registrar

DHMH 17 Rev 7/2009

			For State	State	of Maryla		artment of H rtificate of I		d Mental Hy	giene Reg. No? (136	525
			Registrar 1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month		Year	3. Time of	f Death
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Ĵ	Examin		4a. Facility Name (If not institution WILLIAM HILL		umber)		4b. City, Town, or EASTO		eath		unty of Death ALBOT	1	
Ja ⁻ ₹	- Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir		9. Birth	nplace (State	or Foreign
	Director		213-30-4565	1 □ M 2 🕱 F	79	Yrs.	Months Days	Hours	04/20/	1931		RYLAND	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside C	city Limits
	a-fsh	ctor	MD TAL	вот		EASTO:	N					1 X Yes	2 □ No
	ith the	Dire	10e. Street and Number				10f. Zip Code				n of What Cou D STAT		
	eath w	eral	613 WINDMILL		cedent Ever in (J.S. 13.	2160 Was Decedent of H		? (Specify Yes or No		Race - Amer		
320	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status1 ☐ Never Married 2 X Married3 ☐ Widowed 4 ☐ Divorced	ried Armed F	Forces? 2 X No Bive		If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, P Specify:	uerto Rican, etc.)		Black, White becify: WH		
2-003d	72 hou nature licel E	eted	15. Deceden (Specify only highe	nt's Education	1)	16a. Dece	dent's Usual Occup	ation during most of	working	16b. Kind	of Business/l	ndustry	
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V	filed Hygi other ent, I		17. Father's Name (First, Middle,			111	HOILK	18. Mother's	Name (First, Middle			001001	
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Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	3	19a. Informant's Name/Relations	,					or Rural Route Numb			(ip Code)	
o, O	s 1 and 3 of Health item 27 other tr		JOHN A. ATWOO	D / HUSBA					EASTON, M		tion - City or T	Fown, State	
0	Pages nent of I int: If ite		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (5		n State CH	cemetery, cre ESAPEAE	osition (Name of matory or other place CE CREMAT)	ION (/11/2011		NSVILL		
altimor	+ E £ € .		21. Signature of Funeral Service			CENTE			EIN & NEW				D A
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		V 16	23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that t only one cause on	each line.					arrest,		Approxima Interval Be Onset and	etween
(is.)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	o (or as		n- Non	Sma	11 Cell			onch	ren tt
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X Q Q	th cer tendin r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of preg		□ Ectopic pregnanc	су		23	d. Date of del Month	livery Day	Year
	ne dea the at hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pre 9☐Un	egnant at time o known	f death 5	Other (specify) _				TVI CITAL	Day	
<u>7.</u>	sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as		Part II. Other significant conditi	ions contributing to	death but not re	esulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of	f death?
rds	quires n sign uld be	d by	Alzheimen	5 Dis	rease				1 🗆	Yes 2□	No 3∏ Pr	robably 4	Unknown
	aw red as bee 2 shou	Completed	•						24a. Wa	s an opsy	24b. Were au	utopsy finding completion of	s available
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6	Phys this al dii	1.To	1 Yes 2 No 27. Manner of Death	28a. Da	te of Injury	ER/Outpatie	of 28c. Inju	ry at	ing Home 5 ☐ Res 28d. Describe			ecify)	TURE
0	nding ath. r: Afte e fune	atior	1 Natural 5 ☐ Pendii 2 ☐ Accident invest	ng (Mi igation	onth, Day, Year)	Injury	M 1 🗆	rk?]Yes 2□No					
DIVISION	ir Atte ter dea irecto irecto	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	not be mined 28e. Pla bui	ce of Injury - At Iding, etc. (Spe	home, farm, s	reet, factory, office		28f. Location City or To	(Street and own, State)	Number or Ri	ural Route Nu	ımber,
ב	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifyi	ing Physician: To	he best of my k	nowledge, dea	th occurred at the t	ime, date and	place, and due to th	e cause(s) a	and manner a	s stated.	
	n 24 h	Medical	(Check only 2 Medica one)	I Examiner: On the	basis of exam anner stated.	nation and/or	nvestigation, in my	opinion, death	occurred at the time	e, date and p	place, and due	e to the cause	
	To the complete of the complet	Ž	29b. Signature and title of certifie	er MIT	-/	X	29c. Licens	se number	0.0	29d. Date	signed (Mont	th, Day, Year)	7.1
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		1	119			-				10-0			

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)
APR 12 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month . Physician/ 0:45PM **AMES** CONNIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, AUG. 8 1 M 2 X F Days Hours Min Months 1943 WASHINGTON, DC Director 214-42-3942 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified 1 Yes 2 □ No MD PRINCE GEORGE'S LANHAM ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5619 WESTGATE ROAD USA 20706 or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. à 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 If Yes, Give BLACK 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 N Divorced Year or Dates Ames, Connie Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) LIBRARIAN TECHNICAN PRIVATE 1 YR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ LEROY BROWN GLADYS GARNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ct 5619 WESTGATE ROAD LANHAM, MARYLAND 20706 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. GEORGE AMES/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND 4/8/2011 RIVERDALE CREMATORY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility J.B.JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) SEPTICEMIA Medical Due to (or as a consequence of) **Examiner** INTESTINAL ISCHEMIA Secure fields list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and COLON CANCER burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached to 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 1 No 2X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2**X** No ည 1 M Inpatient 2 DER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury XNatural 5 Pending Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ronton tarahit MD. APRIL 5, 2011 D93946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROINTAN FARAHIFAR 12150 ANNAPOLIS ROAD SUITE B312 GLENDALE, MARYLAND 20769 31. Date filed (Month, Day Year) 32. Registra 's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APK21 Day Year 10MAS ABELL 0309AM 2011 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Шимс BALTZMORE BAUTZMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Maryland Hours 1 X M 2 F 0670271930 Director 80 217-32-3149 Usual Residence of Decedent 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Calvert Lusby Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11538 Durango Road 20657 II S A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No 72 hours after 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Flight Instructor U.S. Air Force marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည and 2 should be Health and Menta Walter Ε. Abell Eleanor Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Burch/Daughter 7455 Burch Road, Port Tobacco, MD 20677 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of once, J. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) St. George Episcopal: 04/21/2011 Valley Lee, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Forgal Society Licenses

Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ DNEUMOINZA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DATS TEMOTHORAX CERTIFICATION APPROVED BY MEDICAL EX MIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury DATS TRAUMATZE CHEST WALL ZNTURT and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Be Completed by Physician/Medical death certificate be ast IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRZAL PZBRZLUZATZON SEPTZC SHUCK 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal Pailure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed?
☐ Yes 2 X No death? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Hospital: Other: Certificate: To 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Subject arive of Valuete coulded with vithin 24 hours after death.

To the Funeral Director; After completed filled in by the funer. injury 1 Natural 5 Pending Accident Suicide April 13 2011 1 ☐ Yes 2 X No 433 Investigation e veniele 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 4 Broches, Island Ra Solomons Island, Maryland determined Roadway Maryland To the Hospital within 24 hours To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10 D0069274 tre zhane APRIL 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENE STREET, BALTZMORE, MD 2/20 22 HF ZHANG State 22

DHMH 17 Rev 7/2009

Registrar

21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

arol Allred Abe		1- For State Registrar	ate of Maryla		artment o <i>rtificate o</i> :		and Menta		Reg. No. 2 ()	11 136	28
Physici	an/	Decedent's Name (First, Midd)		41 11				2. Date of De Month	ath Day Yea	3. Time of Dea	
ledical Exami	ner	Carol A 4a. Facility Name (if not institution	11red n, give street and nur	Abell	—-т	4b. City, Town	, or Location of D	April 13,	2011 4c. County		
		Calvert Memorial Hos				Prince Fr	rederick		Calvert		
Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Months [Min.		 9. Birthplace (State of Foreign) 	
Director		528-46-7086 Usual Residence of Decedent	1 M 2 X F	72	Yrs			03/20)/1939	Country) Uta	.h
ROY		10a. State 10b. County		10c. City	, Town or Local	ion				10d. Inside Ci	
Maryland 28a-f show	٥		vert		Lusby					1 Yes 2	No X
e Maryl	Director	10e. Street and Number 11538 Durango	Road			10f. Zip Cod 206			10g. Citizen of Wi		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23s no 28s-4 sho injury or other traumatic eveet, the Medical Examiner must be notified at noce.		11. Marital Status	12. Was Dec	edent Ever in U				? (Specify Yes or N		- American Indian, Bla	ck,
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212 ould be I Menti mark	일	19a. Informant's Name/Relations			19b. Mailin	g Address (S	treet and Numbe	r or Rural Route Nu	ımber, City or Tow	m, State, Zip Code)	
MD ad 2 should and 27 is		Kathleen A. B	urch/Daugh		7455			ort Tobac		20677 - City or Town, State	
Baltimore, MD pernit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other fraumati		20a. Wethod of Disposition 1 X Burial 2 Cremation	n 3 Removal fro	m State	crematory or ot	her place)				•	
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Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death	n. Do not enter t	he mode of dy	ing, such as card	liac or respiratory as	rrest, shock, or he	art Approximate Between On	Interval
/Medicar :xaminer		Immediate Cause (Final disease or condition resulting in death)	_{a.} Multiple Inju							Deat	h
() Johnson			Due to (or as a b.	consequence o	of):						
5	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	of):						
#	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence o	of):			-			
50, te be executed sysician and burial - transit	ۊ	- UNIDENDED	d.		9 6	 					
50, te be e nysician s burial	Medical	UNPENDED IF FEMALE:	AMENDED 23c If yes o	outcome of preg	nancy				23d. Date of	delivery	
Ox 6876 eath certificate tatending phy for use as the 1	an/k	23b. Was decedent pregnant in the past 12 months?	1 Live bi	rth	2 F6	etal death	3 Ectopic pr	regnancy	Month	-	ear
Sox death c	Physician/W	1 Yes 2 No 9 V Uni		ant at time of de wn	5 O	ther (Specify)	_		1		
O. B. at the de d by the	. 1	Part II. Other significant condit	ions contributing to	death but not r	esulting in the i	underlying caus	se given in Part I			ibute to the cause of de	
S, P.(uires that n signed id be deta	ed by									Probably 4 Un	
Records, The law require ficate has been si	Completed							24a. Was	ppsy p	Were autopsy findings a prior to completion of ca death?	
tal Rec	S							1 ✓ Yes		✓ Yes 2	No
Vital Rec ysicino: The his certificate director, page	e Be	25. Was case referred to medica examiner?		npatient 2	ER/Outpatient		Other N	ursing Home 5	Residence 6	Other:	-
iog Phy After th		1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	of Injury	28b. Time of		Injury at Work?	28d. Describe	how injury occurr auto auto col	ed	
FION treeding death. ctor: /	atio	1 Natural 5 Pend 2 ✓ Accident Inves	stigation		1633 hrs		Yes 2 V No	· L	4.		
Divis al or A s after al Dire	Certification:	dete	d not be		ome, farm, stre d / Highway	-	ce building, etc.	or Town,	State)	er or Rural Route Numb oad, Solomons Islan	
Hospit Fuoers		4 Homicide 29a. Certifier 1 Certifying Pl	hysician: To the best				e, date and place				-,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical	one) 2 Medicai Exa	miner: On the basis o	f examination a		tion, in my opir	nion, death occur		e and place, and o	due to the cause(s)	
	Σ	29b. Signature and title of certifie		,			ense number C.M.E.		29d. Date sign April 14, 20	ed (Month, Day, Year)	
		30. Name and address of person	who completed caus		23a)		♥,IVI.L.		April 14, 20		
			nt Medical Exan	niner 111	Penn Stree		e, MD 21201				
Ş1 Regis	ate	31. Date filed (Month, Day, Year)	2011 32 Re	gistrar's Signat	1. for	K			·	-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Physician/ 0355 A M Eunice Elaine Ashkettle 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington Hagerstown Social Security Number Age (In vrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Davs Hours June 1, 195 Mary land 59 Director 213-64-4602 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director or 28a-f st notified a MD 1 🏋 Yes 2 🗆 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral 716 W. Franklin St. 21740 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Midowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10 th College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elme Leon McAfee Evelyn Harriett Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dustin D. Benner / Grandson 716 W. Franklin St., Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery April19,2011 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gerald N. Minnich Funeral Home 21740 Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) BOX Medical Due to (or as a consequence of) Examiner Securation let earchione Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Yes 9 🗌 Upk Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. use contribute to the cause of death? 3 Probably 4 Unknown 2 No 1 Nes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No this certificate has page 2 funeral director, 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 1 Yes Certificate; To ER/Outpatient 3 DOA patient 2 🗀 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manne f Death 28b. Time of 28d. Describe how injury occurred After 1 Natural injury 5 Pending after death Accident Investigation 2 Accident
3 Suicide
4 Homicide completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check To the within 2 To the F only one 29b. Signature a 30. Name and add ompleted cause of death 8 13H-4 gistrar's Signatui State APR 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Arthur Andrews, Sr. Month Year OIA PRI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham 5. Social Security Numbe . Age (*In yr*s. 69 If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 215-38-3918 1 X M 2 □ F Months Hours 0cfont19ay11941 Washington, DC **Director** Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Lanham 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Completed by Funeral 20706 7411 Newburg Drive death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumetrin. If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insolator/ Pipe Coverer Construction Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Margaret Elisabeth Welsh William Emanuel Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralphine Victoria Andrews -wife 7411 Newburg Drive Lanham, Maryland 20706 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. Metropolitan Crematory 4/14/2011 Alexandria, Virignia 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Donald Vie Borgwardt Funeral Home, Maryland 20705 4400 Powder Mill Road Beltsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiomyopathy Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Renal Failure Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Coronary Artery Disease Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ☐ Pregnant : ☐ Unknown Pregnant at time of death 5 Other (specify) Month Dav Year been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an after death.

I Director, After this certificate has kert in by the funeral director, page 2 s performed? Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fund completed to Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29c, License numbe

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\underline{A}^{\mathsf{M}}$ Physician Helene S. Bland 2011 9:35 16, April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Caroline Denton Caroline Home for Hospice Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2√2 F 85 Yrs 219-14-4306 June 10, 1925 Maryland Director Usual Residence of Decedent alth and Mental Hygiene.

27 is marked other than "natural" or traumatic event the "natural" or traumatic event the "natural" or the traumatic event the properties of the traumatic event the properties of the p 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo Director MD Caroline Preston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21655 6239 Harmony Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Waitress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace E. Dyott Julius H. George, Sr. ٩ Pages 1 and 2 should nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6239 Harmony Road, Preston, MD 21655 Health a James H. Bland/Spouse item 27 r other to 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State = 5 Cambridge, Maryland permit. Page Department of Important: If any injury or once. Mid-Shore Crem. Ctr. 04/21/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee 4. asken 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Lulmonary Immediate Cause (Final Chronic PEARJ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician attending phys IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the detached t o 9 Unknown 9 Unknown σ. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has S autopsy perform The page 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) APR 1

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAH PULIMOOD 912 D Market St Den for MD 2/629 Registrar's Signature

DHMH 17 Rev 1/2001

D0053815

29d. Date signed (Month, Day, Year)

11-02874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible?

State of Maryland / Department of Health and Mental Hygiene Steven Jay Beebe 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ 1547 hrs April 15, 2011 **Medical Examiner** <u>Steven Jay Beebe</u> 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Caroline Castle Hall Rd & Goldsboro Road Goldsboro If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Director CountryGermany 222-54-1591 1 X M 2 F 48 13, 1962 Yrs Dec. Usual Residence of Decedent 10d. Inside City Limits 807 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 X No other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Maryland Caroline Preston, MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4159 Payne Road USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes within 72 hours after specify: White 3 Widowed If Yes, Give Year 1 Yes 2 No specify: 4 X Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) . Pages I and 2 should be filed within 722 ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than or other traumatic event, the Medical Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 7. Department of Health and Mental Hyrisene. Laborer Asplundh 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ PatriciaA. Williams Beebe Robert L. Beebe, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28149 Hickory Hill Road, Federalsburg, MD 21632 Corey Jay Beebe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Bloomery Cemetery Apr21 2011 Federalsburg, Maryland 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PO Box 160 Greensboro, Maryland 21639 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a Coronary Artery Thrombosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Atherosclerotic Cardiovascular Disease Complicated by Cocaine Use Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical x AMENDED 23b per me g915 5-16-11 vt UNPENDED ned by the attending physician detached for use as the burial -Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? 4 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' certificate ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural 1 Yes 2 No 5 Pending death. Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number April 16, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. DOME **Deputy Chief Medical Examiner** 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

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Bar Alla

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Dennis Ray Bryant, Sr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomi malical Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Min. Days 1 ፟ M 2 □ F Months Hours 9/II/1934 76 Director 411-50-3492 TNUsual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2X No MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21874 USA 36387 Poplar Neck Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 XYes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Completed white Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nora Alice Frits William Lonnie Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36387 Poplar Neck Rd., Willards, MD 21874 Patricia Bryant / wife injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of Important: If it 1 Burial 2 Cremation 3 Removal from State First State Crem. 4/13/2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 -3 week Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: . nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown been signed by the sahould be detached Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Division of Vital Be 25. Was case referred to nedical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 🗆 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defluying Prystcian: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) HOUS 619 2011 pleted cause of death (Item 23a) (Type, Print) 100 E, CANFOL ST SKLISBY BA4+1

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		,		Pleas	e Type or Pri						_		•	•
	•		For		State of M	arylan	d/D	epartme	ent of F	Health and	Mental Hy	gien'	e	10001
			StateRegistrar					Certifica	ate of L	Death		Reg. N	16. U	13634
	Physicia Medic		1. Decedent's Name Avery		ast) an Bishop	, Jr					2. Date of De		Day Year	3. Time of Death
0	Examin		4a. Faeility Name (if	not institution, gr	ve street and number)	46.0	10	4b. Ci	ty, Town, o	Location of Deatl	h	4	c. County of Deat	h Mic d
	Funeral Director		5. Social Security No.	1		e (In yrs. la		day) If Uno Month	der 1 Year ns Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th ay, Xear)	9. Bir	thplace (State or Foreign untry) MD
	*	_	Usual Residence of 10a. State					or Location			1/2//	192	9	
	Marylan 28a-f sh otified a	Director	MD	Worce	ster			n Pin	es					10d. Inside City Limits 1 ☐ Yes 2X No
	vith the 23a or 2	Funeral Di	10e. Street and Num	ipper	C+				Zip Code 2181	1			Citizen of What Co	untry?
	ems ems	in.	11. Marital Status	тррег	12. Was Decedent B	Ever in U.S	3.	13. Was Dec	edent of H	ispanic Origin? (Si	pecify Yes or No-		14. Race - Ame	rican Indian.
215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at , the Medical Examiner must be notified at	by	1 Never Marri		Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No			ecify Cuba 2 □X No	Specify:	o Rican, etc.)		Black, White	
-0	hours natur dical	lete	(0	15. Decedent's	Education		16a.	Decedent's Us	sual Occup	ation		16b.	Kind of Business	
35	nin 72 ne. han " e Med	Completed	Elementary/Seco		grade completed) College (1-4 or 5	5+)	,	ife. DO NOT u	use retired)		rking			_
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\sim $_{o}$	be filed ental Hy ked oth ic event	To E	,		shop, Sr	_				18. Mother's Nar	ne <i>(First, Middl</i> e, ace Ric			
N S	should and Me is marl raumati		19a. Informant's Na	•			I 19h	Mailing Addre	ess (Street :	and Number or Ru				Code)
SE	d 2 sh alth a n 27 is er trau		Donna	a Bush	/ daughte	er	11	-		Dr., F				
ore,	ge 1 and 2 should be filed within 72 hours to the Health and Mental Hygiene. If ifem 27 is marked other than "natur or other traumatic event, the Medical!		20a. Method of Disp		☐ Removal from State		lace of emeters	Disposition (N	lame of r other place	ne)	Date	20c.	Location - City or	Town, State
₹¶	Page tment tant: I		4 Donation	5 Other (Spe	cify)					em. 4/1				
Baltim	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signatur of Fur	S Nice Lice	nsee					ss of Facility E iam St.	_		neral	
			23a. Part 1. Enter	ne disease, or co	mplications that caused one cause on each line	the death	n. Do no						, IID ZI	Approximate
, - F	husician/		Immediate Cause (I disease or condition	Final									SRASR	Interval Between Onset and Death
	Medical Examiner		resulting in death)		Due to (or as a	consequ	ience of):	_ 2 (Pr Pulm	1.65 1	0.7		
		Jer	Sequentially list cor if any, leading to im	mediate A	b. Due to (or as a				112%	7 4	11514	5 /2		
	uted d ansit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	lying injury				,						
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	cate be physic s the bu	edica		•	d									
89	certifi ending use as	M/ng	IF FEMALE; 23b. Was decedent		23c. If yes, outcome	of pregnal	ncy	2 Fotoni	o prognance				23d. Date of del	ivery
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours and are death. To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the known in the funeral director.	Physician/Medic	in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 Pregnant at 9 Unknown	t time of d	leath	5 Other	(specify)				Month	Day Year
P.0	that the ned by details		Part II. Other signifi	cant conditions	contributing to death b	ut not resi	ulting in	the underlyin	g cause giv	en in Part I.	23e, Did t	obacco	use contribute to	the cause of death?
sp.	quires en sig ould b	ted									1 🗆	Yes 2	2 □ No 3 □ Pr	obably 4 Unknown
000	faw re has be ie 2 sh	Completed by									24a. Was auto	psy	24b. Were aut prior to death?	opsy findings available completion of cause of
Ä,	n: The ficate n, pag		25. Was case referre	nd to medical					00.5		1 \square Yes	rmed? 2 □ N		2/LTNo
/ita	s certi	o Be	examiner?	-	Hospital:	nt 2 🗆	ED/Out	patient 3	LOtho	ace of Death (Chec			6 Other (Speci	HOSPICA
of	ng Phy ter this neral o	te: T	27. Manner of Death		28a. Date of injui (Month, Day	ν	28b. Tir		28c. Injury work	/ at	28d. Describe h		_	19.170371-10
ion	tendir leath. or: Af the fu	ifica	2 Accident 3 Suicide	5 ☐ Pending Investigati 6 ☐ Could not	on he			М	1 🗆	Yes 2 No				_=1112
)ivis	al or At s after d I Direct d in by	Certificate: To Be	4 Homicide	determine		ry - At ho . (Specify)	me, farn	n, street, facto	ory, office		28f. Location (S City or Tov		nd Number or Rui e)	al Route Number,
.	Hospit 4 hours -uneral ted fille	Medical	29a. Certifier (Check 2	Medical Exa	ysician: To the best of miner: On the basis of ex	kamination	and/or	investigation, i	in my opinio	n, death occurred a	at the time, date a	and plac	e, and due to the o	ause(s) and manner stated
;	thin 2 the F		only one) 3 29b. Signature and t	Certifying Nu	irse Practioner: To the	best of my	knowle	dge, death occ	curred at the	e time, date and pla	ice, and due to th	e cause	(s) and manner as	stated.
	≥ 2 5		200. Signature and	AIS OF COLUMN					9c. License		,	Zad. D	ate signed (Month	, vay, rear)
		ŀ	30. Name and addre	ess of person who	completed cause of de	eath (Item	23a) (Tv	pe, Print)	00	0 200			11/11	
B	A5+1		CHUIA	M WAT		13:00		733	SAC	05 8418 BUS	ly u	B	2180	۷
	Stat Registra		31. Date filed (Month	Day, Year) ΔPR 1:	32. Registra	r's Signat	ure	Som	les					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:04 PM **EDNA** S. BERRIDGE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico lisbur Salisbury Rehabilitation a N ursing Ctr 7. Age (In yrs.-last birthdav) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 Year 1 🗆 M 2 🕱 F Months Days Hours Min MARYLAND 92 0972771918 216-16-9095 Director Usual Residence of Decedent show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits nours after death with the Maryland must be notified at Director 28a-f Yes 2 No MD WICOMICO **SALISBURY** ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 200 CIVIC AVENUE UNITED STATES 21801 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 6 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural" 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. 10 CASHIER RESTAURANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental 0 Page 1 and 2 should be DALCY BELLE SINCLAIR RHODA R. RINKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS P. GIBSON / SON 511 TENNANT CIRCLE, ST. MICHAELS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery crematory or other place
FRIENDSHIP UNITED
METHODIST CEMETERY 04/17/2011 ☐ Donation 5 ☐ Other (Specify) FRIENDSHIP, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERC 200 S. HARRISON ST., EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of atting, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) al eci my Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a attending physician and for use as the burial-transit an that initiated events resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal Geal ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 a Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) Director: After this 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Investigation 🔲 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a Medical 29a, Certifier critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to Pranting the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to Pranting the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to Pranting the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to Pranting the place of the pl Certifying Nei 29c. License number 29b. Signature and title of a

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins

M.D.

William H.

31. Date filed (Month, Day, Year,

APR 13

Please Type or Print in Black Indelible inki Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ernest Butler 6 Day 2 0°111 18:52P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3342 Brinkly Rd. Temple Hills P.G. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 197-32-4534 1 ★ M 2 F Hours Min 66 4-23-1944 GA. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. P.G. Temple Hills 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3342 Brinkly Rd. 20745 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1♥1Yes 2□No If Yes, Give Year or Dates: 11. Marital Status 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married 1 ☐ Yes XI No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Teacher 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown Carrie Gibbs Columbus Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taurus Butler (Son) 5000 Lydianna Ln. #208 Suitland MD. 20746 20b. Place of Disposition (Name of remaining management) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4-14-2011 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Riverdale MD. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHunt Funeral Home Francis 908 Kennedy St. N.W. Wash, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Due to (or as a co IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) Month Day Year 9□ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whitnown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 🗌 Yes 2 NO 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 2 Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28b. Time of

/Medical Examiner The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, the attending physicien Be Completed by Physician/Medical use as tha ŏ signed by the at d be detached for been s certificate has To the Hospitel or Attending Physician: this Certification: After death. Director:

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

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ir than "natural", or itame 23a or Ita Medical Examinar must be

"natural"

Department of Health and Mental Hygiene. Important: If item 27 is marked other than

Physician

Pages 1 g

injury or other traumatic event,

72 hours after

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

Exam

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 🗌 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Medical

29b. Signature and title of certifier

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29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

32. Rec

DHMH 17 Rev 1/2001

Registrar

thin 24 hours a

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within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 April Dwayne Lee Berry Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0nley Montgomery General Hospital Montgomery 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Sept. 11, **Funeral** Year) 1 🛛 M 2 🗆 F Months Days Hours Min. 36 Director 213-86-5566 Sept. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 X Yes 2 No Capitol Heights Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ö 23a Funeral 6209 Baltic Street 20743 United States items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc ō þ 1 X Never Married 2 Married ☐ Yes Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: If Yes, Give Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12th \end{array}$ College (1-4 or 5+) Disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ 1 and 2 should be fit f Health and Mental item 27 is marked Patricia Ann Berry Carlton Lee Sellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seat Pleasant, Maryland 20743 Patricia Ann Berry - Mother 6209 Baltic Street permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t or other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date April 14, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection 2011 Clinton, Maryland 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service License Benning Road NE 20019 Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) MIN Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): as the burial-transit law requires that the death certificate be executed Gause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending IF FEMALE: ase a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ĺ Month Year Day Pregnant at time of death 9 Unknown been signed by the should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 Z Hospital or Attending Physician: The 1 🗌 Yes 2 🗌 No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this in 24 hours after death.

The Funeral Director: After this properties in by the funeral standard. 28a. Date of injury (Month, Day, Year) 27. Manna of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Acciden
3 Suicide 5 Pending 1 🗌 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70226 000 201 nd address of person who completed cause of death (Item 23a) (Type, Print) ADUTH PHILLS Dr

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

3 2011

CLNEY

PRINCE

18/61

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 2011 2:30 PM Mary Ann Bassford Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 45132 Clarks Mill Road Hollywood St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Year) 1 □ M 2 😾 I **Director** 217-32-3341 Maryland December 8, Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important if firen 27 is marked other than "natural", or frame on any injury or other trainmetic. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Hollywood Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24277 Lucky Lane 20636 TISA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married ☐ Yes Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) St. Mary's County Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ C. Alfred Jarboe Dorothy Edith Chance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Bassford, III / Son 45132 Clarks Mill Road, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 21, 1 🖾 Burial 2 🗌 Cremation 3 🗍 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 2011 Hollywood, Maryland Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Signature of Funeral Service Licenses 22. Name and Address of Facility × 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death \mathfrak{D} Ph_sician/ 043 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or if that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed page certificate 1 Yes 2 No Yes 2 ☑ No 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Hospital 6 Other (Specify) 1 ☐ Yes / 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident neral Director: A filled in by the f 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760

Sureshbhai H. Patel, M.D. 31. Date filed (Month, Day, State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check

only one)

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D 62213

22650 Cedar Lane Court, Leonardtown, MD 20650

18

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Ragistrar	Otate of Maryland		rtificate of	Death		Reg. No.		
),			Decedent's Name (First, Middle, Late	st)				2. Date of De	aath Day	Year	3. Time of Death
	Physicia /Medic		Vallie	Ricks Bal	cer			April	17,	2011	6:20 a. M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of De	eath	1	County of Death	
			St. Mary's Nurs		to a to the state of the	Leonar		Irs. 8. Date of Bi		St. Mar	y'S place (State or Foreign
	Funeral Director		5. Social Security Number 6. S 255–12–4804	Sex 7. Age (In yrs. I	ast oinnoay) Yrs.	Months Days		in. (Month, Di	ay, Year)	Cou	Georgia
			Usual Residence of Decedent								10d. Inside City Limits
	anylan	-	10a. State 10b. County	10c. City	, Town or Lo	ocation					1 XYes 2 No
	8a-f	Funeral Director	Maryland St. Mary	's Leon	ardtov	10f. Zip Code			10g. Citiz	en of What Co	untry?
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	ne 23	lera	21585 Peabody St	12. Was Decedent Ever in U.	S. 13.	20650 Was Decedent of H If Yes, specify Cubi	dispanic Origin?	(Specify Yes or N		4. Rece - Amer Black, White	ican Indian,
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3	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or tems 23e or 28e-f show ent, tre Madical Exercise minal be notified at	d by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:							ite
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7	within tene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Bookk				Reta	il Sale	es
3	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's h	Name (First, Middle	, <i>Maid</i> en	Sumame)	
<u>a</u>	ould be Mental Marked o	To	Daniel Johnson				Rilla I				
g	2 sho and is mu raum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street					
ະ ນົ	s 1 and 2 should be filed within 72 hours after death with the Manylan I Health and Mental Hygiene I Health and Mental Hygiene I Health and Mental Hygiene I Health and I have a seen than "natural", or I terms 23a or 28a-1 show other traumatic event, I're Manical Execution runal tean collined at		Jerry Ricks/Son 20a. Method of Disposition	20b. P	3752	6 River Sosition (Name of matory or other place	Springs	Road, Av	enue,	MD 20 cation - City or	0609 Town, State
	9 0 = 5		1 ☐ Burial 2 【XCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specific	_Removal from State				19/2011	Chan	lotto II	a11 MD
Danimo	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	nsee		Ld-Echo1s 2. Name and Addre	4 800 - 124	Brinsfiel			
۵	per Imp any		CMMIPA.		0052 2	2955 Holl					
ğ			23a. Part1. Enter the disease, or corr shock, or heart failure. List only	plications that caused the death	h. Do not en	ter the mode of dyin	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to for as a conseq	uence of):	1 - 1 h	4	E.D.	D 1		
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	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Cozi	ma	ru A.	olor	4 V 25	_		years.
ĵ	exection and and rial-tra	Еха	resulting in death) Last	Due to (or as a conseq	uence of):	1		1	-		0
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ιν _υ Γ	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause gi	ven in Part I.				the cause of death?
ä	w require been sig should b		Atrigi Fr	brillation	,			_ 1_	Yes 2		obably 4 Unknown
Records,	lawr nas be	Completed	Ostsopo	20 yes		1/			s an opsy formed?	24b. Were au prior to death?	utopsy findings available completion of cause of
I E	sicien: The law certificate has l irector, page 2 s		Penpho	ra-NEws	opal	hy		1 ☐ Yes	2 No	1 ☐ Yes	2 No
VII	Physicien: this certific at director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA Ot	her	Death (Check only		6 ∏Other (Spe	cify)
O		 	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time			28d. Describe			
lo I	Attanding Fire death. ector: After by the funeral	atlo	1 ■ Natural 5 Pending 2 Accident investigation	on	injury		Yes 2 □ No				
DIVISION	or Attanation after deati	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ome, farm, s	treet, factory, office			(Street an own, State		ural Route Number,
2	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying P	hysician: To the best of my kno	wledge dea	th occurred at the t	me date and o	lace, and due to th	e cause(s)	and manner as	s stated.
	24 hos Fun etely	edical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or	nvestigation, in my	opinion, death o	occurred at the time	e, date and	place, and due	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	$\Omega \Omega = 0$		29c. Licen	se number	,		te signed (Mont	
			hama	A JarboE	M) D	064	19	Ef	ーセクー	//
			30. Name and address of person who	/ /				1			
9			James P. Jarboe,	M.D. 24035 T	hree N	lotch Road	d, Holly	ywood, MI	206	636	
	Sta Regist		· ·			backer					
DH	MH 17 Rev 1/2	- 1	APR 20	2011 Jane	P. A						

DHMH 17 Rev 1/2001

		•	For State Registrar	Otate of We	il ylalla / i		tificate of		wentar riy	Reg. No		13610
F	Physicia	an.	1. Decedent's Name (First, Middle,						2. Date of De Month	Da	ay Year	3. Time of Death
	/Medic	al	Kenneth	Bruce		Be	ale	100 Co. (Do.)	April		, 2011 c. County of Death	6:10P M
	Examin	er	4a. Facility Name (If not institution, 4210 Rolling A			ļ	Mount	Location of Deat	40	Frederi		
	Funeral			6 Sex 7 Ag	e (In yrs. last bii	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	9. Birth	place (State or Foreign
	Director		218-46-1009	1 M 2 □ F	64	Yrs.	Months Days	Hours Min.	Oct. 3	i, rear	946 Mar	yland
	w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Loc	cation					10d. Inside City Limits
	Maryla f sho	io										1 □Yes 2X□No
	the l	Director	Maryland Frede 10e. Street and Number	FLICK	PIC	ount	Airy 10f. Zip Code			10g. C	itizen of What Cou	intry?
	h with	al D	4210 Rolling A	cres Drive			217	71			U.S	.A.
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin? (5 an, Mexican, Puer	Specify Yes or No to Rican, etc.))-	14. Race - Ameri Black, White,	ican Indian,
215-0036	be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or items 23a or 28a-f show event, the Mydical Everning in ust be notified at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	ed 1 □Yes 2 🔯 1 If Yes, Give Year or Dates:	10	1 ☐ Yes 2 █ No Specify:			Specify: V			
ۍ ح	72 hor	eted	15. Decedent' (Specify only highes	's Education	16a	. Deced	lent's Usual Occup	ation	rkina	1	Kind of Business/Ir	
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<u></u>	shoul and Mark mark umati	ř	19a. Informant's Name/Relationsh	nip (Type. Print)	198	o. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City	or Town, State, Zi	ip Code) 21771
Ž	and 2 alth a 27 is		Linda K. Beale	- Wife	4	4210	Rolling	Acres D	rive, Mo	unt	Airy, M	aryland
ore O	es 1 a of He fitter		20a. Method of Disposition 1 XBurial 2 Cremation	2 Demount from State	20b. Place o	of Dispos	sition (Name of natory or other place	ce)	Date	20c. l	_ocation - City or T	own, State
Ĕ	Pag Iment tant: I		4 □ Donation 5 □ Other (Sp		Prov		ce Meth.		/15/11		nrovia,	
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev		21. Signature of Funeral Service	Censee Willi	ems)	M 22	Name and Addre	ss of Facility h-Willian ge Road	ms P.A.,	Fu	neral Ho Marylan	me d 20872
			23a. Part 1. Enter the disease, or	complications that caused	the death. Do						110171011	Approximate Interval Between
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	ertifica ing ph	Medical	IF FEMALE:									
ROX	eath cer attendir for use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal deat		Ectopic pregnanc	су			23d. Date of deli Month	very Day Year
o.	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/N	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 L	Other (specify) _					
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Z II	clan: ertific octor,	Be (25. Was case referred to medical examiner?				1		ath (Check only			
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DIVISION	r Attender death	fica	3 ☐ Suicide 6 ☐ Could n	ot he	ury - At home, f	arm, stre	eet, factory, office	1100 20.10			and Number or Ru	ral Route Number,
2	al or safter	Certification:	4 ☐ Homicide determi	building, et	c. (Specify)				City or To	wn, Sta	te)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier 1 CertifyIn (Check only one)	g Physician: To the best Examiner: On the basis of and manner st	f examination a	je, death nd/or in	occurred at the t vestigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time	e cause , date a	(s) and manner as nd place, and due	stated. to the cause(s)
	orthe omple	Mec	29b. Signature and title of certifier		A.O.U.		29c. Licens	se number		29d. D	ate signed (Month	n, Day, Year)
L	F>F0		Chilital	yengne			D424	452		Αn	ril 12, 2	2011
•			30. Name and address of person	who completed cause of c			Print)					
	4		Chira Rajago	·		rin	ce Philip	Drive,	Olney,	Maı	ryland 20)832
	Sta Registr		31. Date filed (Month, Day, Year) APR 1	3 2011 32. Registr	ar's Signature	1. 1	barre					
			AL IV A	1			7.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April Physician/ Nancy Lee Boone 7:30 PM 16, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 219 East Sixth Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Hours July 24 Year) 1935 1 M 2 XF Mary land 75 215-32-1732 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. Count Director 1 Yes 2 No Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code U.S.A. 21701 Funeral 219 East Sixth Street Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2X No 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Etta Mae Unknown Louis V. Garver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 South Grant Road, Thomasville, PA 17364 19a. Informant's Name/Relationship (Type, Print) Mark Boone, son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens April 21, 2011 Frederick, MD 21. Sign sure of unoral Servi Keenev and Bastord PA Funeral Home M00255 21701 106 East Church Street, Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death endometrial cances Immediate Cause (Final METERGETIC Physician/ mi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transif that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate being the round of the control of the control of the attending physicials. Funeral Director: After this certificate has been signed by the attending physicial eted filled in by the funeral director, page 2 should be detached for use as the burent of the funeral director, page 2 should be detached for use as the burent of the funeral director. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Descripting Projection. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig D0067691 April 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 W 7 St. Frederick MD 21701 D (dSTEIN G 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 0215 M R. Basner 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death 8. Date of Birth (Month, Day, Y Sept. 14, 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Months 1 🕱 M 2 🗆 F Country) Michigan Hours 174-48-3653 55 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🖾 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1023 Eastern Shore Dr. Apt. 3 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: 3 Wildowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Manager Rental Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Basner Jacqueline Hollywood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Basner- wife 630 Dover St. Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 4/12/2011 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home Signature of Funeral Service Licenses Salisbury, MD 21804 Main St. 23a. Part 1. Enter the disease, or complishock, or heart failure. List only on dictions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, because on each line.

Brain Death clue to Intra (vanid Remorr) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition d Date of delivery

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H70755

Physician/ Medical Examiner

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director; After this certificate has

Physician/

Medical

Director

Funeral

Completed by

Be

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MD

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fam 27 is marked other than "natural" any injury or other transmitted.

Completed by Physician/Medical Examiner Be Certificate: To

> (Check only one 29b. Signature and title of certifie

> > GAYDER

31. Date filed (Month, Day, Year,

SONTI

Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.		buse contribute to the cause of death? 2 No 3 Probably 4 Unknow. 24b. Were autopsy findings available
		autopsy performed? 1 \(\sum \text{Yes} 2 \(\sum \text{1}\)	prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		28d. Describe how inju	ury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Physi	ician: To the best of my knowledge, death occured at the time, date and place, a	nd due to the cause(s)	and manner as stated.

State Registrar 540 SNOW All RD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April q^{Day} 2011 Dennis Edgar Baird 9:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dorchester Hurlock 6110 Wanda Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Idaho .Year 945 1 🙀 M 2 🗆 F Months Days Hours Min March 5, Director 518-48-5753 66 Usual Residence of Decedent or 28a-f shov 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Hurlock 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6110 Wanda Road 21643 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1962-82 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Warrant Officer U. S. Army permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar A. Baird Alice Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Baird wife 6110 Wanda Road, Hurlock, MD 21643 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 4/11/11 Delmar, DE 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 45CVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): g physician a Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year 1 Yes 2 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has 2 HNo 1 Yes Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier NAKN 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 1634 N 1415 Svew SALISBURM VU 5. DIV 1510~ 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04 08 2011 Day Physician/ Gary V. Botto 02:10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Salisbury Wícomico 826 S. Schumaker Dr., Apt. 302 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1**X** M 2 □ F Davs Hours 05/05/1955 200-46-9364 56 Director Pennsylvania Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Wicomico Salisbur 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 826 S. Schumaker Dr., Apt. 302 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes. Give Specify: "natural", Completed 3 Widowed 4 X Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 2 Electric Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ George Botto Anita (unknown) pe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Joyner/girlfriend 826 S. Schumaker Dr., Apt. 302, Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury Crematory 4/12/2011 Salisbury, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses ²² Name and Address of Facility
HOILOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death patoma Physician/ Medical resulting in death) Due to (g as a consequence of) Examiner Sequentially list conditions, Examiner sequentiary ist contains, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Month Year 5 Other (specify) Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accounted at the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my kingwledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat re and title of certifier 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type MD 21801 Scelis 600sta 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 13 2011 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Ellwood R. 2. Date of Death 3. Time of Death Barton Physician/ Month Year 20/ TPY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death alonal If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Age (In yrs. last 8. Date of Birth 9. Birthplace (State or Foreign 78 03/23/1933 Maryland 216-28-3026 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 149 Shamrock Drive 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Russell Barton Flora Manger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 149 Shamrock Dr., Salisbury, MD 21804 Patricia Barton/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date springhill Memory Springhill Memory Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/16/2011 Hebron, MD Physician. Medica Examine attending physician and for use as the burial-transit page 2 should certificate

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir

	21. Signature of Funeral Service License		²² Holloway funeral 501 Snow Hill Rd	Home Profession, Salisbury, M	nal Association ID 21804			
	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	t enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death			
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23b. Was decedent pregnant in the past 12 months? 1						
Completed by P	Part II. Other significant conditions cor	tribute to the cause of death? 3 □ Probably 4 🌠 Unknown Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
Ba	25. Was case referred to medical examiner?	oocital.	26. Place of Death (Che	1 Yes 2 No				
잍	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ospital: 1	ne of 28c. Injury at	ner (Specify) red				
Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	a, street, factory, office	, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State)				
Medical Certificate:	(Check 2 Medical Examine	er: On the basis of examination and/or in	ath occured at the time, date and place, a nvestigation, in my opinion, death occurred age, death occurred at the time, date and pl	at the time, date and place, and du	ue to the cause(s) and manner stated.			
4	29b. Signature and title of certifier	rahi	29c. License number 020912	7/10	ed (Month, Day, Year)			
	30. Name and address of person who co	mpleted cause of death (Item 23a) (Type W. M. A. 400 C	pe, Print) 5. SHOLC Dr. Shlow	skip mo				
te ar	81. Date filed (Month, Day, Year) APR 13 2011	82. Registrar's Signature	aks	, , , , , , , , , , , , , , , , , , ,				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Dea	th	Reg. No.	
hysici Exami		Decedent's Name (First, Middle,Last)			3. Time of Death Year 0534 hrs
-Xeiiii		Heather Allen Cowgill 4a. Facility Name (if not institution, give street and number) 4b. City	Town, or Location of Death	April 4, 2011 4c. Coun	ty of Death
		Memorial Hospital Eas		Talbo	
ineral rector		Mon		8. Date of Birth(MM/DD/YY	Foreign
ector		187-50-5720 1 M 2 F 45 Yrs.		09/22/1965	CountryPennsy1v
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
f show	ō	Maryland Caroline Greensboro			1 Yes 2 No
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ns 23a or 28a-f sho be notified at once			639 Hent of Hispanic Origin? (Spec	USA	ace - American Indian, Black,
items	Funeral		cify Cuban, Mexican, Puerto Ri		hite, etc.
iner m	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:		y: White
Exam			I Occupation (Give kind of wor orking life. DO NOT use retired		Business/Industry
than edical	Completed	12 Unemploye	d		
other the M		17. Father's Name (First, Middle, Last)	18.Mother's Name (F	irst, Middle, Maiden Surna	me)
mental rygiene. marked other than "natur c event, the Medical Exami	Be	James Joseph Coughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	Judith Haves (Street and Number or Run	wley Hughes	Journ State Zin Code)
tant: If item 27 is m or other traumatic	Ţ	•	ol St., PO Box		
If item		20a. Method of Disposition 20b. Place of Disposition (N	ame of cemetery,		on - City or Town, State
Important: If injury or other		4 Donation 5 Other Specify: Chesapeake	CrematoryApr.	6,2011 Chest	er, Maryland
mport		21. Signature of Funeral Service Licensee 22. Name an	d Address of Facility PO BOX 160 e and Helfenbe	, Greensboro	, MD 21639 Home, P.A.
ician		27a. Part I. Enter the disease, or complications that caused the death, Do not enter the mode			
alcul.	3	failure, List only one cause on each line. Immediate Cause (Final disease a. Pulmonary Thromboembolism			Between Onset and Death
niner		or condition resulting in death) Due to (or as a consequence of):			
	F	Sequentially list conditions, if any, leading to immediate b. Right lower extremity deep vein thrombo Due to (or as a consequence of):	sis		
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated			
ansit	Еха	events resulting in death) Last Due to (or as a consequence of): d.			
ian an	Medical	UNPENDED AMENDED			
physician and the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy			of delivery
the attending phed for use as the	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Sp		cy Month	n Day Year
the att	hysi	1 Yes 2 No 9 V Unknown 9 Unknown			
53	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.		ntribute to the cause of death? 3 Probably 4 Unknown
After this certificate has been signed uneral director, page 2 should be dete	ted				b. Were autopsy findings available
has be e 2 sho	Completed			autopsy performed?	prior to completion of cause of death?
tificate or, pag		25. Was case referred to medical	26 Place of Death (Check on	1 Yes 2 No	1 Yes 2 No
his cer directo	o Be	examiner?	Tour	Home 5 Residence 6	Other:
After t funeral	T:U	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		8d. Describe how injury occ	urred
	atic	2 Accident Investigation	1 Yes 2 No		
al Dir	Certification:	3 Suicide 6 Could not be determined (Specify)	y, office building, etc.	or Town, State)	mber or Rural Route Number, City
		4 Homicide 29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the Check only 1	e time, date and place, and du	ue to the cause(s) and man	ner as stated.
문항	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in n and manner stated.		he time, date and place, an	d due to the cause(s)
o the Fur			9c. License number		gned (Month, Day, Year)
Young 24 nours arer deam To the Funeral Director: completely filled in by the	Me				K14.1
within 24 hours after death To the Funeral Director: completely filled in by the	Me	Calumn 1999	O.C.M.E.	April 5, 2	
To the Fur Completely	Me	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Stre	O.C.M.E. et, Baltimore, MD 2120		

CROSS EDWARD

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		1	For State Registrar		Sta	ate of M	arylan			ent of F ete of E		and M	ental Hy	/giene Reg. N	2011	13647
	D.	,	Decedent's Name	e (First, Middle	, Last)								2. Date of De	ate of Death 3. Time of Death		
Physician/ Medical EDWARD LEE CROSS												APR:	1 5	· · · · · · · ·		
	Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De DOCTORS COMMUNITY HOSPITAL LANHAM					of Death		1	RINCE G							
	Funeral Director	5. Social Security Number 241-38-5378 6. Sex 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. APRIL 20,1						9. Bir L931 NOR	thplace (State or Foreign CURITY) CAROLINA							
	ind show at	ត	Usual Residence of 10a. State	Decedent 10b. County			10c. City	y, Town or L	ocation							10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD	PRINC	E GEOR	GES	RIV	ERDAL	Ξ							1 ☐ Yes 2🌠 No
	ith the 23a or st be n	ralD	10e. Street and Nun		TE DOA	D 4 D T	7 17	2		Zip Code 20737				10g. C	itizen of What Co	ountry?
	eath w	Funeral	6815-E R	CIVERDA	12. Wa	s Decedent B			Was Dec	edent of Hi	ispanic Ori	igin? (Spec	ify Yes or No		14. Race - Ame	erican Indian,
Baltimore, Maryland 21215-0036	e flied within 72 hours after death with the Maryland tral Hygiene. So with a "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Marr 3 Widowed		ied 1 [ned Forces? Yes 2 X es, Give or Dates.	No			ecify Cuba 2 X No			tican, etc.)	:	Black, White Specify: BLA	
15-(72 hou n "nati	Completed		cify only highe	it's Education st grade com			(Give	kind of w	ual Occupa ork done o se retired)		t of workin	g	16b. k	Kind of Business	Industry
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altir	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 21. Signature of 5 ur				WAS									The second second second
ä	Per E E	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL 7474 LANDOVER ROAD, HYATTSVILLE, MD						LE, MD 2	20785							
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Division of Vital Records,	tal or Al rs after al Direct ed in by		4 Homicide	determi	ned 28e.	Place of Inju building, etc			reet, facto	ry, office		2		(Street and Number or Rural Route Number, wn, State)		ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2		caminer: On t	he basis of ex	kamination	and/or inves	stigation, i	n my opinio	n, death oc	ccurred at t	he time, date :	and place	nd manner as st e, and due to the s) and manner as	cause(s) and manner stated.
	To t with To t		29b. Signature and t	title of certifier	p	10			25	D005	number 50951				ate signed (Mont. 5/2011	h, Day, Year)
12	_ 5		30. Name and addre					, , , , ,	,	E, SU	ITE 2	400.	RIVERI	DALE	, MD 207	737
	Stat Registra	e ar	31. Date filed (Month		Genera	32. Regidira				, 30.					. – – – .	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death April 10 ay 2011 ear Physician/ 7:56 A M Salvador Medina Covarrubias Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 3342 Tidewater Ct Olney 5. Social Security Number 6. Sex X M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. F&611341948 457-73-6598 63 **Director** Mexico Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 🔀 Yes 2 🗌 No Maryland Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20832 Mexico 3342 Tidewater Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 √ Yes 2 No Specify: Mexican If Yes, Give Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Construction Wildcat Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Conrado Avitia Maria Covarrubias 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 2405 Kinderbrook Lane Bowie, MD 20715 Abel Medina (Son) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 04/15/2011 | Silver Spring, MD Gate of Heaven 4 Donation 5 Other (Specify) Signature of Juneral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home race 9013 Annapolis Rd. Lanham, MD 20706 23a. Par 1. Enter the diseas- or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List, mix and cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Arteriosclerotic cardiovascular Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner If any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Dille to for as a consequence of that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ COPD 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 XN To the Hospital or Attending Physician; "within 24 hours after death.

To the Funeral Director; After this certifics 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner's Other: 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending 1 🗌 Yes 2 🗎 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death oc curred at the time, date and place, and due to the cause(s) and manner as stated. Api

Registrar

State

31. Date filed (Month, Day,)
APR 1 3 2011

Edward Taubman18109 Prince Philip Dr. Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20 Year 6:30 AM M GREGORY FRANCIS CENEVIVA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 8109 Laurel Ridge Road Frederick 5. Social Security Number 6. Sex 1 A M 2 A F If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Year) 947 March, Day, Pennsylvania 64 Yrs. Director 207-36-2146 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8109 Laurel Ridge Road 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 'natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 721 realth and Mental Hygiene.
vm 27 is marked other than "er traumatic ever" than Elementary/Seconday (0-12) College (1-4 or 5+) Mortgage Company Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Angelo Ceneviva Margaret Mildred Plantulli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Ceneviva / Wife 8109 Laurel Ridge Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 🗆 Other (Specify) 4/14/2011 Sepulchre Cem. Glenside, Pennsylvania Signator of Funeral Service license 22. Name and Address of Facility
Robert E. Dailey & Son Funeral Homes, P.A.

Frederick Maryland 21701 , Frederick 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final AN ENO CARCINOMA Onset and Death THE LUNG Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or se a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 031761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOI W, SEVENTH ST. BRIAN M. 0 CONNOR 21701 MD 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav 14:48 nase Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TAKOMA Par ton omery If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In yrs last birthday 8. Date of Birth g. Birthplace (state or Foreign 1 XM 2 🗆 F Months Days Min 3-4-1941 **Director** Maryland 70 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 ☐ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2118 Dennis Rd 20601 USA and Mental Hygiene. is marked other than "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1967

If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. B<u>lack</u> 3 Widowed 4 Divorced Completed Year or Dates. 1969 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Service Technician Washington Gas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Chase Lucille Eugene Oueen permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Chase / Wife 2118 Dennis Rd, Waldorf Maryland 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place any injury or 4 Donation 5 Other (Specify) Maryland Veterans 4-18-11 Cheltenham MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 0 disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to a r as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran the attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate I performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No မြ Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA 1 AHMED 31 BLUD Silver MO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

APR 1

32. Registrar's Signature

11-02503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

рато	rner Cle	gg,	State of Maryland / Department of 1-For State Certificate of Registrar		ygiene 2011 3551
	Physici al Exam		1. Decedent's Name (First, Middle,Last) Opa Turner Clegg, III		2. Date of Death Month Day Year April 1, 2011 3. Time of Death 0809 hrs
5			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Euporal		Prince Georges Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cheverly If Under 1 Year If Under 24Hrs	Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
	Funeral Director		579–90–8673 1X M 2 F 39 Yr	Months Days Hours Min.	July 12,1971 Foreign Country Maryland
			Usual Residence of Decedent		
	OW AR		10a. State 10b. County 10c. City, Town or Local	tion	10d. Inside City Limits 1 X Yes 2 No
	Aaryland 28a-f show any 1 at once.	Director	Maryland Prince Georges Largo 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
;	the Ma a or 2 tified		511 Harry S. Truman Drive; Apt. 407	20774	United States
:	Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiens and statural", or items 23a or 28a-f sho usit. If item 77 is marked other than "natural", or items 23a or 28a-f sho usit. If item 77 is marked other than "natural", or items 23a or 28a-f sho nr other traumatic event, the Medical Examiner must be notified at once,	Funeral		as Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto	
ľ	ter dea		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:	Specify: Black
	led within 72 hours afte Hygiene. I other than "natural", the Medical Examine	d by	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decede	nt's Usual Occupation (Give kind of w	vork done 16b. Kind of Business/Industry
ထွ	n 72 h nan "n lical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life. DO NOT use retire	That yeard bept. Of
8	filed withi Hygiene. d other th	Щ Щ	17. Father's Name (First, Middle, Last)	al Operations Man	(First, Middle, Maiden Surname)
21215-0036	uld be file Mental Hy marked o	Be	Opa Turner Clegg, Jr.	Celena	Collins
0 21	should and Me 77 is ma natic ev	ဥ	(4),	·	tural Route Number, City or Town, State, Zip Code)
MD.	permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery.	y; Hyattsville, Maryland 20784 Date 20c, Location - City or Town, State
Baltimore,	ages l ant of F at: If i		1 Burial 2 X Cremation 3 Removal from State crematory or o	her place) Apr: Park Crematory	il 13,2011 Riverdale,Maryland
alti	mit. P partme porta				N. Horton Company Morticians
		3		:.;600 Kennedy St	reet, N.W.; Washington, D.C. 2001
	ysician Vedical		failure. List only one cause on each line.	ne mode of dying, such as cardiac of	respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
≟x	aminer		Immediate Cause (Final disease or condition resulting in death) a. Intraoral Gunshot Wound Due to (or as a consequence of):		
		_	Sequentially list conditions, if any, leading to immediate b		
		Examiner	cause. Enter Underlying Cause (Lusease or injury that initiated		
	ted Insit	Exa	events resulting in death) Last Due to (or as a consequence of):		
	e be executed ysician and burial - transit	ledical	UNPENDED AMENDED		
760,	cate be physic the bur	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery
Box 6876	ending Puysician: The law requires that the death certificate be executed are. Tr. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi	Physician/N	past 12 months?	etal death 3Ectopic pregnal her (Specify)	ncy Month Day Year
8	the att	hysi	1 Yes 2 No 9 Unknown g Unknown		
Р.О.	that th med by detach	by	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
ds,	w requires s been sign should be	Completed			24a, Was an 24b. Were autopsy findings available
of Vital Records,	e law i te has b ge 2 sh	Idu			autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
<u>₩</u>	certificate ector, page	BeC	25. Was case referred to medical	26.Place of Death (Check of	
Z	bysician: r this certif al director,	ToB	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatien		Home 5 Residence 6 Other:
O	h. After ti funeral	ü	27. Manner of Death 1 Natural 5 Pending Apr 1, 2011 Pay Year) 28a. Date of Injury Apr 28b. Time of O710 hrs		28d. Describe how injury occurred Subject shot self
<u>:0</u>	3 9 5 5	ficati	2 Accident Investigation 28e Place of Injury - At home farm stre		28f. Location (Street and Number or Rural Route Number, City
<u>S</u>	Hospital or 24 hours afte Funeral Dii tely filled in	Certification	3 Suicide Gould not be determined Gould not be determined	į	or Town, State) 511 Harry S. Truman Drive #407, Largo, MD
Į.	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only one).		
Ę	To the comp	Medical	2 Medical Examiner: On the basis of examination and/or investigated and manner stated. 29b. Agriquire and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	3	=	() exteres ()	O.C.M.E.	April 7, 2011
0	V		30. Name and address of person who completed cause of death (Item 23a)		
L 9	X		Laron Locke MD. Assistant Medical Examiner 111 Penr	Street, Baltimore, MD 2120	01
	St	tate	31. Date filed (Month Day Year) APR 132 201 Percent 32. Registrar's Signifure		

Physic		1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Cert	ificate of De	eath ————		2. Date of Dea	eg. No.		1 3 6 5 i
Physic Tedical Exam		Tamera Elizabeth Cl	owes-Gladkov	vski			Month April 17, 2	Day 2011	Year	0454 hrs
		4a. Facility Name (if not institution, give street Meritus Medical Center	and number)		ity, Town, or Lagerstown	ocation of Death		1	County of Death ashington	
Funeral Director		5. Social Security Number 6. Sex 183–48–9239 1M 2	7. Age (In yrs. las		Under 1 Year onths Days	If Under 24Hrs. Hours Min.	8. Date of B	rth (MM/DI	9. Birth Poreign 1957 Penn	nplace (State or Mysylvania
ny		Usual Residence of Decedent 10a, State 10b, County	10c. City, T	own or Location						10d. Inside City Limits
nd show a	<u> </u>	Maryland Washington		hsburg						1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unit: If item 27 is marked other than "natural", or items 23a or 28a-f show any rother fraumatic event, the Endickal Examiner must be notified at once.	Director	10e. Street and Number 50 Geiser Way		101	. Zip Code 217	83			n of What Count	try?
with t ms 23s	eral		Vas Decedent Ever in U.S			anic Origin? (Sp Mexican, Puerto		0- 14	4. Race - Americ White, etc.	an Indian, Black,
er death , or ite	Funeral	1 Never Married 2 Married 1 3 Widowed 4 Divorced If Yes.	Yes 2 No	1 Yes	-V		,	s	_{pecify:} Whit	te
ours aft. Itural" Iamine	d by	15. Decedent's Education (Specify only high	es:	16a, Decedent's U	sual Occupation				nd of Business/In	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other fraumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	Federal	_		euj	Dep	artment	of Defens
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than	Con	17. Father's Name (First, Middle, Last)	i		1	3.Mother's Name	(First, Middle,	Maiden Si	urname)	
1215 1 be file ental H urked o	Be	Reuben Clowes		V		Janet Do				Zio Codo)
MD 27	10	19a. Informant's Name/Relationship (Type, Pr Joseph Gladkowski-hu		19b. Mailing Add		and Number or R Smithsb				Zip Code)
e, M 1 and 2 Health item 2		20a. Method of Disposition	20b. PI	ace of Disposition ematory or other p	(Name of cem		Date		ocation - City or T	Town, State
MOF Pages nent of ant: If		1 Name Burial 2 Cremation 3 Ref	St.	Luke Ce	metery		3-2011		ot, PA	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee Kattyn Saffarina	1			of Facility Dou on Blvd.				ral Home MD 21742
Physician	_	23a. Part I. Enter the disease, or complication	s that caused the death. [Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Seps)								Death
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	edic		NDED					Load	Date of delivery	
876 rtificate ing phy as the	M/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna	ancy 2 Fetal de	eath 3	Ectopic pregna	ncy	1		ay Year
Box 68760, e death certificate by the attending physic ed for use as the bured for use as the	Physician/Medical	1 Yes 2 No 9 V Unknown	Pregnant at time of dear	th 5 Other (Specify)					
O. B. at the de I by the tached f			outing to death but not res	sulting in the under	lying cause gi	ven in Part I.				he cause of death?
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Yital Recor Physician: The law r r this certificate has b	Be	25. Was case referred to medical examiner? Hospital	1 Inpatient 2 E	ER/Outpatient 3		Mhor	g Home 5	Residence	ce 6 Other:	
of Vital ing Physician After this cert funeral directo	n: To	27 Manner of Death 28	a. Date of Injury	28b. Time of Injury	28c. Injury		28d. Describe Subject fell		y occurred tub of home	
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Division tal or Attendin safer death.	Certification:	Suicide Could not be	Be. Place of Injury - At hor Specify) Bathtub of h		логу, опісе ві	liding, etc.	or Town, 50 Geiser W			ai Noble Humber, Oily
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely likely in by the funeral director, page 2 should be detached for use as the buin		29a. Certifier 1 Certifying Physician: To	the best of my knowledge	e, death occurred a	t the time, dat	e and place, and	due to the cau	se(s) and	manner as state	d.
To the within 's To the complete	Medical	one) 2 Medical Examiner: On the and m	e basis of examination and anner stated.	d/or investigation, i			t the time, date			
	Σ	29b. Signature and title of certifier	1 1 10	\circ	29c. License O.C.M	OOME			ate signed <i>(Mon</i> 18, 2011	ui, Day, Tearj
		30. Name and address of person who complete	red cause of death (Ifem)	232)						
OV	'	30. Name and address of person who comble	ted candoe of death (item 2	.00/						

Theodore M. King, Jr., MD.

State 31. Date filed (Month, Day, Year)

Registrar APR 28 2011

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3653 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ADC SHILLEN 4a. Facility Name (if not institution, give street and number, Medical 2011 **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES MEDICAL ENTER 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2XXF Days Months Hours Min. MAR 6 **Director** 1941 MARYLAND Yrs. 485-48-0943 70 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f st notified MD CHARLES 1 🗌 Yes 2 🔀 No LA PLATA 10e. Street and Numbe ō 10f. Zip Code r items 23a or ner must be n 10g. Citizen of What Country? Funeral 10640 VILLAGE DRIVE 20646 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? "natural", or iten edical Examiner 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER 12 AT HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ JOHN EDWARD MIEDZINSKT MARY IRVA MCKAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trains CLYDE J. COPSEY/SPOUSE 10640 VILLAGE DRIVE LA PLATA, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State APËÏL 1 X Burial 2 Cremation 3 Removal from State TRINITY MEM.GRDNS. 20,2011 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND Signature of Funeral Service Licenses 22. Name and Address of FacilitRAYMOND FUNL. SERVICE, P.A. Bota 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Carl disease or condition YO Medical resulting in death) Due to ras a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Day Month Year Yes 2 No 9 Unknown 9 I Itnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ಲ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Marge Pylactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu ann address of person who completed cause f death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

H-08800 #H

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HAR

2 8 2011

Centennial Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician 2011 Arthur Donovan 09, 1:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Talbot Hospice House Easton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year. Months Days Hours 213-05-4700 95 Director 1916 Delaware Feb. Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Caroline Federalsburg 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4954 Preston Road 21632 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatin enem. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2 No Specify: Specify. White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sign Construction Sign Maker 11 (Grad) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lilly Wheeler James Donovan ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4954 Preston Rd., Federalsburg, MD 21632 Shelva Jean Gray/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Odd Fellows Cemetery 04/12/11 Seaford, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic 6 mouth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician requires that the death certificate be Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) the 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s autopsy page performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes After this of funeral dire 5 ☐ Residence 6 Nother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 🔲 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature ar D 00538/5 9120 Market St Wuton MD 21629 Name and address of person who completed cause of death (Item 23a) (Type, Print) KORAT+ 4c/MOOD 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year SARAH X50N Medical County of Death 4a. Facility Name (if not institution, give street and number) or Location of Death **Examiner** inton lunch If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** Country) Months Min. 1 □ M 2 💢 F 228-36-5953 78 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Norfolk City Norfolk 1X Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 453 Peppermill Lane 23502 United States permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Beautician Comestology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Edward Webb Lucy Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley D. Wade/Daughter 2318 Timbercrest Drive, Forestville, Md 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Carver Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/13/2011 Suffolk, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pole Funoval Homes. P. A. 5538 MANLBOND PIKE 20747 Forestville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or lart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ pancreatic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 1 Yes After this certificate has been stuneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 No Yes 2 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 . No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No death. 2 Acciden Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Fractioner: To the course of the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title 29d. Date signed (Month. Day, Year) License number

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>011</u> April Physician/ Robert Meredith Donovan 20 12:19 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert 8. Date of Birth
(Month, Day, Year)
July 24, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-26-7968 **Director** 79 Delaware Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's Charlotte Hall 1 🗆 Yes 2 🖾 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 29449 Charlotte Hall Road 20622 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 4 Yes 2 No Black, White, etc ρ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Printing Sales Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Avery K. Donovan Emma H. Wight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank H. Horner/brother eta05 Sunset Lake Blvd., Venice, FL 34292 April 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Brinsfield-Echols 1 Durial 2 K Cremation 3 Removal from State 21, crem. Charlotte Hall, MD nation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 Notch Rd., Charlotte Hall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. nd Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** equantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23h Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month isigned by the a 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown has been sig 24a. Was an Were autopsy findings available prior to completion of cause of autopsy certificate ha death? Yes Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Dotth 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending neral **Director**; A I filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check 🛄 Medical Examiner: On the bacts of ekamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one Signature a

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 1 201 fear Clarence Dudley Dillard April 10:45A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number Birthplace (State or Foreign Country)
 DC If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 📉 2 🗆 F 579 86 5621 2/18th 7961 50 Yrs. **Director** Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Prince George's Clinton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8105 Fawn Court 20735 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 XNo Specify Specify: Black 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed witt... Mental Hygiene. '~d other than "r '* the M (Specify only highest grade completed) Give kind of work done dunng most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th ead Systems Analyst BAE/ Private Be permit. Page 1 and 2 should be flec Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other transcript 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick R. Dillard, Sr. Susie Mae Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aeronita B.Dillard/Wife 8105 Fawn Ct. CLinton, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Surial 2 Cremation 3 Removal from State 4/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. Clinton, MD Signature of Funeral Service Livensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami SPIRATOR executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be untithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗌 No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day, Year)

State Registrar

NB)0

31. Date filed (Month, Day, Year

SURRATTS

KOAD. CLINTON,

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:38A M Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Ot Marylana hmore If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Year g. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Hours Min FEB 21 **Director** 74 1937 NORTH DAKOTA 501-42-8550 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits 1 🗌 Yes 2 🏻 No CHARLES MD NEWBURG 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13581 SOUTH VIEW ROAD 20664 U. S. A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify Specify: "natural", 3 Widowed 4 Divorced Completed WHITE the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) DEPT. OF AGRICULTURE ECONOMIST Be Department of Health and Mental Inportant: If item 27 is marked any injury or out 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOSEPH WILLIAM DELVO ANNA ARENDES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FAITH DELVO / WIFE 13581 SOUTH VIEW RD., NEWBURG, MD 20664 20b. Place of Disposition (Name of cemeterv. crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST.JOSEPH'S CEM. 26,2011 POMFRET, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND Signature of Funeral Service Licenses $^{22.\ Name\ and\ Address\ of\ Facility}$ RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646in M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or all a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy 3 Į in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify, hours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work 2 🗌 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AMPT 11, 2011 Ricardo Del Mundo 10:02 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 225 5th Street Lothian Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Funeral Min. Month, Day, 1 □ xM 2 □ F 214 60 2934 57 Washington DC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Maryland Anne Arundel Lothian 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 225 5th Street 20711 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**XX**No 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 XDivorced Filipino Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Painter Home Improvement Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Jose Del Mundo Lucia Elizabeth Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Frances Hook (Daughter) 8239 Doctor Cralk Court, Alexandria, Va 22306 20c. Location - City or Town, State 20b. Place of Disposition (Name of 4/15/2011 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Clinton, MD Mary Piscataway Ch Cemetery . Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence resulting in death) Last Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Ses 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director; After this certificate has performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day 2011 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13660 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month :50 PM WINSTON SR ELLIS OF 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days Hours Min. 1 🛛 M 2 🗆 F NEW YORK 97 713-10-2786 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 No PRINCE GEORGES BOWIE MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20720 US 12901 WOODMORE NORTH BOULEVARD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give ARMY Year or Dates. Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) US POSTAL SERVICE LETTER CARRIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KATE **AGATHA** THORNHILL MARTIN DEAN ELLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12901 WOODMORE NORTH BLVD., BOWIE, MD 20720 WINSTON ELLIS, JR. / 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4/12/2011 RIVERDALE, MD RIVERDALE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD, HYATTSVILLE, MD 20785 Part 1. En ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart allure. List only one cause on each line. Immediate Cause (Final Onset and Death DNETMONTA

Physician Medical **Examiner** Examine

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

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rral", or items 23a o Examiner must be

"natural", or

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27 is marked other than r traumatic event, the M

27

Department of Health Important: If item 2: any injury or other to

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

21215-0036

Maryland

Baltimore,

completed filled in by the

Physician/Medical

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Completed

To Be

Medical Certificate:

29b. Signature and title of certifier

RODNEY L.

31. Date filed (Month, Day,

APR 1 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELLIS, M.D.

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

disease or condition	INECTIONIA			_ ,,,,,,,,,,,			
resulting in death)			1 MONTH				
Sequentially list conditions,	ASPIRATION PNEUMONIA						
if any loading to impediate cause. Enter Underlying	Due to for as a consultance of,						
Cause (Disease or linjury that initiated events	CEREBROVASCULAR ACCIDENT			1 YEAR			
resulting in death) Last	Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	elivery			
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Month	Day Year					
Part II. Other significant conditions cor	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	o the cause of death?			
		1 🗆 Yes	2 X No 3□ F	Probably 4 Unknown			
		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s			
25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)					
1 ☐ Yes 2 🕅 No	ospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing He	ome 5 Residence	6 Other (Spec	cify)			
27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? M 1 Yes 2 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
(Check 2 Medical Examination	cian: To the best of my knowledge, death occured at the time, date and place, are: On the basis of examination and/or investigation, in my opinion, death occurred at Practioner: To the best of my knowledge, death occurred at the time, date and place.	t the time, date and plac	ce, and due to the	cause(s) and manner stated			

29c. License number

D0021326

9811 GREENBELT ROAD #104, LANHAM, MD 20706

29d. Date signed (Month, Day, Year) 04/08/2011

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2011 Physician/ Leonie Leanora Ellerbe 9:30 PM April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LaPlata Charles Genesis Nursing Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Birthpia Country) NY 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Hours Min. 1 17671937 1 M 2 XF 73 131 44 9044 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10c. City. Town or Location Director 1 XYes 2 No MD Charles Waldorf 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11889 Homestead Place 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify: Black Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th US Post Office Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Ethel Habashaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) portant: If item 27 it y injury or other trau Jahmal Earl Ellerbe/ Son 11889 Homestead Pl.Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of 1 Burial 2X Cremation 3 Removal from State mportant: If 4/16/2011 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crem. 21, Signature of Funeral Service Lice 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601 ke, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure Li Approximate Interval Between Onset and Death Immediate Cause (Final) Due to (on as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 1 Yes 2 g Unknown s been signed by the should be detached Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Hospital Other: 2 No 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No ✓ Natural nours after death.

neral Director: After dilled in by the fur 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) thin 24 hours a the Funeral D mpleted filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

rslausbit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Colony

32. Pegistrar's Signature

DY. SUTR

29c. License number

0070900

Annopolis

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2011 **Physician** 12:15 PM Genevieve Florence Glover /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 307 Caroline Avenue Caroline Ridgely If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1 □ M 2 X F Yrs March 14 77 1934 Delaware Director 214-32-1139 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State r than "natural", or items 23a or 28a-f show the Medical Experience must be notified at 1 X Yes 2 □ No Director Caroline Maryland Ridgely 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21660 USA 307 Caroline Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No White Specify Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mental once. Elementary/Secondary (0-12) College (1-4or 5+) store clerk package goods 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Holden Mondel Semans ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 21660 307 Caroline Avenue; Ridgely, James Glover, Sr. / husband 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State April 12 2011 Ridgely, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ridgely Cemetery 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
PO Box 160; Greensboro, MD 21639 21. Signature of Funeral Service Licensee PO Box 160; Greensboro, MD 2.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic **Physician** eals /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infunediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has 2 🗆 No this certificate 1 □Yes 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my online. death assured. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 1) 0 0 5 7 8 15 29b. Signature and title (Item 23a) (Type, Print)
Market Strut Deuton M 2/629 10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

9/21 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Itemstate of Maryland & Department of Health-and Mental Hygiene 1- State Registrar #11, per f.home, 4/15/11, Certificate of Death E.T, WCHD Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4^{Month} 3. Time of Death Physician/ 20 T1 Clarke Robert Goodwin 4:15 Рм Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin 35 Chatham Court If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 8 / 1 9 / 1 9 3 2 9. Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) **Funeral** 178-26-4089 78 **Director** Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director MD Worcester Berlin 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? TOD Funeral 21811 USA 35 Chatham Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give ð 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Diversed Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 7 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) (CZ) Funeral Director Death Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ida Morrow Clarke H. Goodwin 19 32 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marlene Goodwin/wife 35 Chatham Ct, Berlin MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/11/11 First State Crem Millsboro Other (Specify) 21. Signatur of Freral, errice Licenses 22. Name and Address of Facility St 21811 108 William Burbage Funeral Home Berlin MD 23a. Part. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a construence of): WOLD BY disease or condition resulting in death) Medical Examiner Eumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): u a the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATI Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 X Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 2005 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No Natural Accider 5 Pending Accident Unknown Subject fell Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) Circle, Glenshaw, PA determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: (Check the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 0 19 3 29d. Date signed (Mohm, Day, Year) only one) 40056241 Chris Suydr npleted cause of death (Item 23a) (Type, Print) WO BA 5+1 2181 10344 Olean 31. Date filed (Month, Day, Year) State APR 1 3 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 7:30 P^{M} Joyce Gross 2011 <u>Apri</u>l Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince George's St. Thomas More Nursing Home 8. Date of Birth (Month, Day, Yea March 26, Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Min. 1 □ M 2 🖾 I 1965 Washington, DC 578-02-8694 Director 46 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 4922 LaSalle Road 20782 USA items (Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ò ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates "natural", Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) District of Columbia al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Social Services Child Care Technician 12 event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Charles E. Gross, Sr. Marjorie Pleasant other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Victoria Gross / Sister 4451 Oakdale Crescent Ct., #3312, Fairfax, VA 22030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Harmony Cemetery 4/14/2011 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligense 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or comilio tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) AIDS <u>Years</u> Medical Due to (or as a consequence of): Examiner Sepsis Days Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Day 1 ☐ Yes 2 ☑ 9 ☐ Unknown be detached 9 | Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed?

☐ Yes 2 🔀 No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🔀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 24 hours after death. Funeral Director: After Hospital or Attending (Month, Day, Year) 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the To the 29b. Signature and title of certifier D68583 4/12/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Tanyech Walford,

31. Date filed (Month

32. Registrar Signat

9101 2nd Avenue, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P^{M} Ada Mae Green pril 2011 6:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Larkin Chase Nursing Home Bowie Prince George's 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 Months Days Hours Min. 01/06/1930 Country SC 251 66 2861 **Director** 81 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits 1 XYes 2 No Forestville MD Prince George' 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8104 Steve Drive 20747 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black 3X Widowed 4 ☐ Divorced Completed Year or Dates al Hygiene. I other than "naturs vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Menan injury or other traumatic event injury or other event injury or othe College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Dietician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Friday Jessie Gee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 Steve Dr. Forestville,MD 20747 Jonathan Gee/ Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other placel 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mt.Lawn Cemetery 4/12/2011 Woodford, VA 22. Name and Address of FacilityCedell Brooks Funeral Home 21. Signature of Funeral Service License 25662 A.P.Hill Blvd.Port Royal,VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) Advance Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner trany, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Dav 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Multiple Decubitus Ulcers 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension 24a. Was an has autopsy performed page 2 After this certificate 2 N 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: ျ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \sum Yes 2 \sum No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 Homicide determined Medical *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) D0051437 04/12/2011

Registrar DHMH 17 Rev 7/2009 Okeowo

D 31. Date filed (Month, Day, Year)

NB2

Fairwood Internal Medicine

Glenn Dale, MD 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ibitoye

APR 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 Day Physician/ Aprill 201^Y 6:51A. Andrew Gentner, Jr. Walter Medical 4b. City, Town, or Location Silver Spring 4a. Facility Name (if not institution, give street and number) Town, or Location of Death c. County of Death Montgomery Examiner Holy Cross Hospital 7. Age (In yrs. 88 If Under 1 Year If Under 24 Hrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-16-8821 1 XM 2 □ F Months Days Hours April Day 22,1922 Washington, DC **Director** Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Prince George's Silver Spring Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a o event, the Medical Examiner must be with 1 Funeral 20904 United States 3160 Gracefield Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Ford 1 X Yes If Yes, Give ed Forces? Black, White, etc. 1 Never Married 2 Married ve (unk) þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Completed 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (154 or 5+) and Mental Hygiene. Physiologist Dept. of Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rosa Olga Meyers Walter Andrew Gentner, Sr. 19a. Informant's Name/Relationship (Type, Print)

J. Guy Bell -Personal Rep. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health at
Important: If item 27 is
any injury or other trau 6246 Franklin Gibson Road Tracys Landing, MD 20779 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Metropolitan Crematory 4/16/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma Maryland 20705 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Upper Gastrointestinal Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Acute Gastritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the aid be detached for 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2【 No 24a. Was an autopsy performed? Yes 2 X No has page 2 certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 X ER/Outpatient 3 Inpatient 2 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury after death 2 Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Deece D36716 April 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death GANJEH Year Physician/ 0 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balknuc If Under 24 Hrs. 8. Date of Birth al Security Numbe 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Min. Jan:14, 1943 1 □ M 2 🙀 F Kerman, 68 none Iran Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Lutherville Maryland Baltimore 10f. Zip Code 21093 10g. Citizen of What Country? 10e. Street and Number Funeral Iran 14 Abbey Bridge Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Caucasian If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7. Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fatemeh Jabbarzadeh ျ Mahmoud Ganjeh traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Abbey Bridge Court Lutherville, MD 21093 Mohammad Ali Sistani -son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4/14/2011 MD National Mem. Park |Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Dônaldov:Bofgwardt Funeral Home, 4400 Powder Mill Road Beltsville, ν_{ι} Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 Ŋ 9 ☐ Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy perforn death? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes မ 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pt 124 hours after death. e Funeral Director: After the leted filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Detrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu e and title of certifie 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltonec, Mary Jane W: 160.7 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

28 2011

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

104

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 28 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mirza-aliKhani

29c. License number

11711 Livingston Road, Foit Washington, MD

29d. Date signed (Month,

Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Hubbell Carol Ambrose 1:57PM Medical 2011 pril 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbot Genesis Health Care The Pines Easton 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign 09-14-1918 1 M 2 2 F Months CA. 92 **Director** 559-62-5109 Usual Residence of Decedent or 28a-f show notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits Talbot 1 X Yes 2 No Md. Easton 10e. Street and Number ö 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 610 Dutchmans Lane 21601 USA "natural", or items dical Examiner mu 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. vvas Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own home Be arol Hubb ore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be Ambrose rtment of Health and Menintant: If item 27 is marke njury or other traumatic Arthur Warren Alma Locke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F.William Pfordt/son inlaw 24519 New Post Rd., St. Michaels, Md. 21663 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Direct Cremetory 04-07-11 4 Donation 5 Other (Specify) Dover, Delaware pernit.
Dep rtn
Importa eral Service Licensee Signati Bennie Smith Funeral Home Street, Easton, Md. 21601 426 Dover Part 1. Enter the disease, or complications that caused the deal Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ ADULT PAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ARDIOVASCUL Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit OBSTRUCTIVE resulting in death) Last Due to (or as a consequence of Physician/Medical certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Pregnant at time of death Month Day Year a 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R133336 who completed cause of death (Item 23a) (Type, Print) itchmans Ly Eastern MD 21601 31. Date filed (A

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
 Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Norris LeRoy Harrison PM Medical 3 • 30 April 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death enesis Health Care Pines aston der | Year | If Under 24 Hrs. | Talbot **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Hours (Month, Day, Ye MAY 14, 1 220-03-5312 MARYLAND Director 88 1922 Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1
▼ Yes 2 □ No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 214 SOUTH WASHINGTON STREET 21601 UNITED STATES and Mental Hygiene.
is marked other than "natural", or iterraumatic event, the Medical Examiner. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 X Yes 2 □ No 1942-If Yes, Give 1945 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Black, White, etc. 1 Never Married 2 Married within 72 hours after is Harrison Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 1945 3 Divorced 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 OWNER TRUCKING COMPANY Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FRED S. HARRISON **ELEANOR LOMAX** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a THERESA HARRISON / DAUGHTER 416 A. GLEBE ROAD, EASTON, MD other! Baltimore, t of Hea Ifitem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 🕱 Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) JOSEPH'S CEMETERY 04/13/2011 CORDOVA, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on e Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 0223 Medical Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Tue to (or as a consequence of): the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No ned by the a s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autonsy performed Yes 2 death? or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1.XNatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be М 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) tchmans Ln Easton MD 21601 State

Registrar

Norr

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HARRIS MARIE ALICE APRIL 7 2011 9:26 P 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🕱 F Days Min. NOV • 24 Hours NORTH CAROLINA 238-64-8998 Ĩ939 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🎦 No PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 23rd PARKWAY #305 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. BLACK 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2YRS CATER PRIVATE 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Malden Surname) SAM PITT SARAH NEWTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY NEWTON/Niece 85th PLACE NEW CARROLLTON, MARYLAND 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SUNSET MEMORIAL PARK | 4/18/2011 FARNVILLE, NORTH CAROLINA J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility Signature of 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between re. List only one cause on each line

Ph_sician/ Medical **Examiner**

> burial-transit physician s the burial

To the Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

MD

Director

Funeral

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Examiner

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Director

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ms 23a o must be

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be filed within 72 hours after death

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Ith and Mental F 27 is marked of traumatic ever

Department of Health a Important; If item 27 is any injury or other trains

Baltimore, Maryland 21215-0036

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	Immediate Gause (Filed disease or condition resulting in death)	a POLYMICRORIAL SEPS	513	Onset and Death
ler.	Securationly list conditions, if any, leading to immediate	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
Exami	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Due to (or as a consequence of): Due to (or as a consequence of):	CTION	
edicai		d		
nysician/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of de Month	livery Day Yea r
ed by r	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e, Did tobacco use contribute to	
			autopsy prior to performed? death?	topsy findings available completion of cause of s 2 No
מ	25. Was case referred to medical examiner?	26. Place of Death (Check	(only one)	
2	T LI Yes 2 LS No	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Ho	me 5 \square Residence 6 \square Other (Spec	ify)
ווכמוב	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not by	(Worth, Day, Year) Injury work? M 1 \(\sum \) Yes 2 \(\sum \) No	28d. Describe how injury occurred	
	4 Homicide determined		28f. Location (Street and Number or Ru. City or Town, State)	ral Route Number,
3	29a, Certifier 1 Certifying Phys	ician: To the best of my knowledge, death occurred at the time, date and place, any	d due to the course(s) and manner so at	atod.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

20735

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar

eral Director: After filled in by the funer

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To the Funeral D

completed filled in

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ath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 0947 SHARDN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner (ENTER MEDICAL UNIVERSITY OF MARYLAND TIMOR 7. Age (In yrs. last birthday Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🕱 F Months Hours Min. (Month, Day, Year, Country) District of Columbia 66 Yrs Director 29. 219-46-5220 1944 Usual Residence of Decedent 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Waldorf Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3733 Pecan Court 20602 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nortant in item." 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🖾 No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert McKinney Moore Catherine Ellen Linkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelly Marie Scott / Daughter <u> 787</u>0 Tall Oaks Place, Charlotte Hall, MD 20622 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 15 cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Alexandria, Virginia Metropolitan Crematory Signature of Funeral Service bicense Mattingley-Gardiner Funeral Home, P.A. 22. Name and Address of Facility P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SUBDURAL Physician/ TEMATOMA disease or condition resulting in death) DAVS Medical Due to (or as a consequence of): Examiner BRAINSTEM Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Other (specify) Day Pregnant at time of death s been signed by the same should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 sh autopsy performed Yes 2 death?
1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 ເ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury DOWN FALL STAIRS 04/05 Investigation ~ 1900 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 completed filled in by the funeral director, after death within 24 hours a

4 LI Homicide	determined	building, etc. (Specify)	City or	TOWN, State) ECAN CT. WALDORF, MD
(Check 2 L	Medical Examiner	r: On the basis of examination and/or investigat	ured at the time, date and place, and due to the ion, in my opinion, death occurred at the time, dath occurred at the time, dath and place, and due to	te and place, and due to the cause(s) and manner stated.
29b. Signature and titl	le of certifier	Alato, no	29c. License number	29d. Date signed (Month, Day, Year) 0 4 / 13 / 11

BALTIMORE, MD

MARTIN D.

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNIVERSITY OF MARYLAND MEDICAL CENTER

31. Date filed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2011 Physician/ Year 6:02p William Haines Sr. April Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11433 Mountain View Road Montgomery Damascus Social Security Number If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1 M 2 □ F Months Hours Min Director 213-14-6584 90 Yrs. Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Damascus 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11433 Mountain View Road 20872 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 ☐ Never Married 2 🖾 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced White any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 8 Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Haines Sr. Rosie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey D. Haines 1433 Mountain View Road, Damascus, Maryland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Montgomery Methodist Cemetery Important: 4 ☐ Donation 5 ☐ Other (Specify) Damascus, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed burial-transit Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 s autopsy 1 Yes 2 No 1 🗌 Yes 2 📈 No To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifies **Division of Vital** director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 📈 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 K Residence 6 Other (Specify) s after death.

| Director: After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 2 ☐ Accider
3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined completed filled in Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Discretifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 Honon 32. egistrar's Signature State nuns

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 1 ear Physician/ Month 4 Charles Ronald Hubbard 2:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 1 X M 2 □ F Months Hours Min. (Month, Day, Year) 5 / 5 / 1 9 4 8 Washington 212-54-6270 **Director** 62 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director MI Lenawee Tecumseh 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 110 S. Oneida St. 49286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married þ 72 hours after ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give "natural", Completed 3 Widowed 4X Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. food co. district manager Be 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Parkman 17. Father's Name (First, Middle, Last) Elmer Donald Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 2508 Brown Farm Ct., Brookeville, MD20853 Cynthia McFall (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematorry4/7/2011Smithsburg, MD 20a. Method of Disposition ☐ Burja P ☐ Removal from State 4 Donation 5 ☐ Other (Specify) ²²Dona1AdreBo FaThompson Funeral Home POB 18, Middletown, MD 21769 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate heart failure. List only one cause on each line, Interval Between Immediate Cause (Final Onset and Death Cardio vascular disease Physician disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sacurately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No |은 1 Inpatient 2 Proutpatient 3 Inpatient 2 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00028429

State Registrar General Hospital 18101 Prince Phill,

who completed cause of death (Item 23a) (Type, Print)

CHERNA

Montgomery

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4000 Physician/ 2010M Anna Helen Hartman 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Medical Center Meritus Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Month, Day, Year) ay 28, 1924 Min. Maryland 1 M 2 F **Director** Yrs. 219-12-0114 86 May Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No MD Hagerstown Washington 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 13021 U.S.A. Clopper Road 21742 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important, If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homecare Caregiver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert R. Rohrer Helen Sarah Willet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13021 Clopper Rd., Hagerstown, Maryland 21742 Kenneth R. Hartman / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 4/18/2011 Hagerstown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel MD 21742 1601 Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Hemmanas cove rovoscular disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Exami that the death certificate be executed nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Mellits 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes Division of Vital 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မ 1 Impatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work I hours after death.
uneral Director: Aft
ed filled in by the fur 1 Tes 2 🔲 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Fractioner: To the best of my knowledge 29b. Signature and title of certifier 110061117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merins Nedical Center 5/1-2 Daniels Da 31. Date filed (Mont Year) 32. **⊯**gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2:00 P. M Physician/ April 13° 20**1**°1 Henry Hageman John Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery City, Town, or Location of Death **Examiner** 3116 Gracefield Road, VP107 Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Feb. 15% 1922 1 **∑** M 2 □ F 89 577-24-5687 Washington, DC Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County Oc. City, Town or Location Silver Spring 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director Maryland Montgomery 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States 3116 Gracefield Road, VP107 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? 1 XYes 2 ☐ No Black, White, etc. or i 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: It Yes, Give Year or Dates 1942-1945 Specify: "natural", 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Electrician Government Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary E. Erb 17. Father's Name (First, Middle, Last)
Paul Victor Hageman 19a. Informant's Name/Relationship (Type, Print)
Nancy Hageman GogLio -daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 905 Wild Forest Drive Gaithersburg, Maryland 20819 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4/19/2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 Dan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final End Stage Dementia Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician and s the burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Herpes Zoster; Leukocytosis; Hypothyroidism 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the irector, page 2 s autopsy performed? Yes 2 No death? After this certification and all the sections of the section of the secti 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 XNo Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred thin 24 hours after death.

the Funeral Director: After mipleted filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

To the F

complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 14, 2011 D44156 ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 28 2011 Registrar

P.O. Box 68760 Division of Vital Records,

Baltimore, Maryland 21215-0036

Certification: To 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and itle of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signat State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ,^{Day}2011 Physician/ Hochmuth Sr. April 11, 7:46 John Alexander Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Delmar 10137 Snethen Church Road 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday **Funeral** 1**X** M 2 □ F Months Days Hours 1171871926 Maryland 84 **Director** 217-36-1572 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Wicomico Delmar Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21875 10137 Snethen Church Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 Midowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice E. Good မ George Joseph Hochmuth 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 10348 Norris Twilley Rd., Delmar, MD 21875 19a. Informant's Name/Relationship (Type, Print) Pat M. Hochmuth/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date springhill Memory
Gardens 1 X Burial 2 Cremation 3 Removal from State 4/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCVD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 1 Yes VI No 1 Yes Ye No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes No ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: √1 □ Natural injury 5 Pending 1 🗌 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of centifier 29c. License number D63199 4/12/11 ess of person who completed cause of death (Item 23a) (Type, Print)

VOHRA 915 EASTORN SHORE DF, SACISBURY 30. Name and 21804. Whi OCTES

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0035 M Emily Jane Jackson Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HIOMICO Medical Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year)
Tuly 21, 1930 Funeral 1 □ M 2 🔀 Months Hours 220-26-8373 Maryland 80 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland at Director notified Vienna 1 Yes 2 X No 28a-f Dorchester MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code iral", or items 23a or Examiner must be Funeral 21869 United States 4853 Old Rte. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Specify:Black Maryland 21215-0036 hours after 1 Yes 2X No Specify If Yes, Give "natural", 3 XWidowed 4 Divorced Completed Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Owned Sewing Center Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie Smith ၉ John Dennis permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clarence Jackson, Jr./Son P.O. Box 37, Vienna, MD 21869 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 04/19/11 Fastern Sh. Veterans Cem. 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line et and leath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Securativity list ecoditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregn 3 Ectopic pregnancy 5 Other (specify) ____ Month in the past 12 mg Day Year Pregnant at time of death signed by the a Yes 2 1 Yes 2 2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ₩No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed' 1 ☐ Yes 2 ☐ No After this certificate **Division of Vital** • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 0041261 30. Name and address of person who corpoleted cause of death (Item 23a) (Type, Print) Acle MO Camil Street Salisbury 3 00l Ternando 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 1642 Physician/ Lucia Jeanty 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) 5 Social Security Number **Funeral** 1 M 2 3 F Months Days Hours Min. Haiti **Director** 579 15 4132 Usual Residence of Decedent of Health and Mental Hygiene. Item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director 1 Yes 2 ☐ No Silver Spring MD Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe Funeral United States 20903 1028 Quebec Terrace, Apt. Tl 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Specify: Haitian/Black þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None Unemployed 5th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental H 7 is marked of ည Belzamonde Pierre Louis Antoine Jeanty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau 7200 Karen Anne Dr., Temple Hills, MD 20748 Granddaughter Nadege N. Fevry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Silver Spring, MD 04/23/2011 Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home LLC 21. Signature of Funeral Service Licensee 20017 3005 12th Street, NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ed by the a detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed b Completed by 1 ☐ Yes 2 k No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of 24a, Was an cate has b autopsy death? 1 Yes 2 No or Attending Physician: The 1 ☐ Yes 2 ₩ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be Other: 1 Ampatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d, Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation after death Director: / 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify 29c. License number April 5, 2011 D0070793 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Sami Mourad, MD

1500 Forest Glen Road, Silver Spring, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 12, Day 2011 Physician/ 8:15 A Jr. Jesswein Adolph John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Ft. Washington 624 Rosier Road 9. Birthplace (State or Foreign ocial Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗓 ЖМ 2 🗆 F Months May 1924 Arkansas 299-18-3486 86 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X XNo Ft. Washington Prince George's Maryland 10e. Street and Number 10g, Citizen of What Country? Funeral USA 20744 624 Rosier Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces?

12 Yes 2 No 1943-Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 K No Specify: If Yes, Give Year or Dates. 1946 White 3 ₩Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Engineer Naval Research Lab. years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Adolph John Jesswein Ida Jewe11 Clemmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Swieczkowski/Daughter 624 Rosier Road Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 104/18/2011 4 Donation 5 Other (Specify) Suitland, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur of Funeral Service Licens 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year jo Month Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy certificate has performed' death? 1 ☐ Yes 2 ☐ No 2 No nin 24 hours fer death.

the Funeral Director After this certific inpleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2X X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 은 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury XX Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 04-12-2011 1170/ living Ston NH 10/ fx WAshyton ano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

1.0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Month Anne Jennings April 2011 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 1 □ M 2 💢 F Days Months Hours Min 08/21/1930 Yrs. 80 10b. County 10c. City, Town or Location Leonardtown 10f. Zip Code

For State Registrar . Decedent's Name (First, Middle, Last) Physician/ 20 թ.ա Medical 4a. Facility Name (if not institution, give street and number) Examiner 22680 Cedar Lane Court Social Security Number 9. Birthplace (State or Foreign **Funeral** Washington, DC Director 577-42-7960 Usual Residence of Decedent 28a-f shov 10a. State the Maryland notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland St. Mary's 10e. Street and Number ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral with 22680 Cedar Lane Court 20650 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Was Decedon Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced White the Medical 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည traumatic Charles Stewart Thomas Beniti Peacock .. Page 1 and 2 should tment of Health and M tant; If item 27 is ma jury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Styles/Daughter 17790 Rosecroft Road, Lexington Park, MD 20653 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/21/2011 James Cemetery Lexington Park, MD Signature of the service of the serv 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD Jr. 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HUMGU DISTAGE Sequentially list conditions, Examine it any leading to immedia cause. Enter Underlying PENTER 8701 the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Day Pregnant at time of death 4 Pregnant 9 Unknown the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy certificate 2 No Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at work?
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Box 68760 Division of Vital Records, P.O.

29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation only one) 1 Certifying Physician: To the basis of examination and/or investigation only one)	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner state
29b. Signature and title of pertifier	29c. License number	29d. Date signed (Month, Pay, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		7

41688 Miss Bessie Drive, Leonardtown, MD

20650

State Registrar 31. Date filed (Mor.

Boyd, M.D

APR 2 0 201

DHMH 17 Rev 7/2009

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		1 - State Registrar		Cert	tificate of l	Death		Reg. No.		
		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
Physic		Clifton E. Jame	es				March	26	2011	8:40P M
/Med Exam		4a. Facility Name (If not institution, give sta	reet and number)		4b. City, Town, or	Location of D	eath	4c. Co	ounty of Death	
		Lorien Assisted	Living		Mt.	Airy			Carrol:	
Funera	1	Social Security Number Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Bir Min. (Month, Da	th y, Year)	9. Birthp	place (State or Foreign ntry)
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ens er m	Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	i. 13. W	Vas Decedent of H Yes, specify Cuba	lispanic Origin' an, Mexican, P	? (Specify Yes or No uerto Rican, etc.))- 14	 Race - Americ Black, White, 	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No 194 If Yes, Give Year or Dates: 196	1 1	□Yes 2XNo	Specify:		S	pecify:	White
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the de	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	satii 5	Journal (speary)					
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dsol hon une inne	ca	29a. Certifier 1 ☑ Certifying Phys (Check only 2 ☐ Medical Examit	ician: To the best of my kno ner: On the basis of examina	wledge, deatl tion and/or in	h occurred at the t vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time	e cause(s) a e, date and	and manner as place, and due	stated. to the cause(s)
To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	one)	and manner stated.		29c Licen	se number		20d Date	signed (Mont)	h Day Voar)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7, 1:30P M 2011 Alberta Donne Johnston April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3230 Preakness Drive Mount Airy Carrol1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 30, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Yrs. 293-24-9201 83 Ohio Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland Carrol1 Mount Airy 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 3230 Preakness Drive 21771 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Štatus Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2**X** No Specify: White Specify: 2 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be inent of Health and Mental nt of Health and Ments:
If item 27 is marked
r or other traumatic ev Anna Elizabeth Hendershot Albert Layman Hardesty 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3230 Preakness Drive, Mount Airy, Maryland Ralph W. Johnston - Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 04/11/2011 Pine Grove Cemetery Mount Airy, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicense 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home govert Damascus, Maryland 26401 Ridge Road, 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical as attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ e e 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4€ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 □ No or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check one) Tipletely and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 29b. Signa

Mohit Narang M.D.,

1

31. Date filed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Rugistrar's Signature

D0067468

555 South Center Street, Westminster, Maryland

April 8, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1213 PM Ohnson 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Months Days Hours Min. NOV^{ntt}9 , 1931 SOUTH CAROLINA Director 79 247-52-7250 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location the Medical Examiner must be notified at Director PRINCE GEORGES CAPITOL HEIGHTS 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES items 23a 20743 1110 DRUM AVENUE within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1954
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: BLACK "natural" 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CEMENT TRUCK DRIVER CONSTRUCTION injury or other traumatic event, Be t. Page 1 and 2 should be filed rtment of Health and Mental Hi rtant: If item 27 is marked ot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) LIZZIE JOYNER JOHNSON TIMOTHY JOHNSON, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE JOHNSON/WIFE 1110 DRUM AVENUE, CAPITOL HEIGHTS, MD 20743 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD VEIERANS CEMETERY 4/19/2011 CHELTENHAM, MD Signature of Funeral Service Licensee THORNION FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 LIPIAC. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ DEMENT/A Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 the attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death as been signed by the 2 should be detached g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires HADENI ENSION Records, 1 Yes 2 No 3 Probably Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed page death? 1 Yes 2 No ☐ Yes 2 L Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 욘 this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death.

Director: Aft 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the P 29b. Signature and title of certifier 000 58290 13/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riverdale un 20737 SURESH KUMAN 5711 Savice Ave. such 200 HIATT UM

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Beverly Ann Kerns April 2011 8 04:40AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10607 Hunters Chase Lane Damascus Montgomery 8. Date of Birth (Month, Day, Year) Sept. 24, 1962 Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days 1 M 2 Hours Min. Director 219-88-5347 48 Washington, DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 🔳 No Montgomery Maryland Damascus 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral within 72 hours after death with 10607 Hunters Chase Lane 20872 USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ed other than "natural", or iter event, the Medical Examiner 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ■ No Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Instructional Assistant Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. William R. Ponton other traumatic Beverly Beach Ponton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale R. Kerns/ Husband 10607 Hunters Chase Lane, Damascus, Maryland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place 1 🗆 Burial 2 🛡 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Crematorium Inc. April 9,2011 Alexandria, Virginia 21. Signature of Ineral Service 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home jauler 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final 10 1/2 Years Physician/ disease or condition resulting in death) Metastatic Breast Cancer Medical Due to (or as a consequence of) **Examiner** Prior Stage 1 Breast Cancer 15 Years Sequentially list conditions Examine if any, leading to in medicause. Enter Underlying Due to (or as a consequence of the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy 5 Other (specify) ____ Po in the past 12 months?
1 ☐ Yes 2 ■ No Day Year 4 ☐ Pregnant a
9 ☐ Unknown Pregnant at time of death signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? has performed Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Matural 5 Pending (Month, Day, Year) injury after death. Accident Investigation 1 Tes 2 No the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the pasts or examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) re and title of certifier 29b. Signa 29d. Date signed (Month, Day, Year) D0037236 April 8, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hendricks, 6410 Rockledge Drive, Suite 506, Bethesda, MD 20817 Carolyn B. MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar	C	ertificate of	f Death	1	g. No.	13587
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month APRIL	Day Year 5 2011	3. Time of Death
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)	Examin	er	4a. Facility Name (if not institution, give street and number FREDERICK MEMORIAL HC	SPITAL	4b. City, Iown	or Location of Death		4c. County of Dear	
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthda	y) If Under 1 Yea	ar If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
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Z	permittinger and 2 should be the water to the control of the contr	-	19a. Informant's Name/Relationship (Type, Print) Gloria Kefauver (Wif	e) $\frac{195}{31}$	ailing Address (Stre 5 W • Ma	et and Number or Run in St.,	ral Route Number, C Middlet (ity or Town, State, Zi DWn, MD	2 7 769
b	item item		20a. Method of <u>Q</u> isposition	20b. Place of Di	sposition (Name of		Date 20	Oc. Location - City or	Town, State
OLL	nt: If		X Burjal 2 ☐ Cremation, 3 ☐ Removal from S 4 ☐ Denation 5 ☐ Other (Specify)	Reform	rematory or other p	tery 4/9	/2011	Middlet	
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S de de	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dica	d						
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VISION OF	r deat ctor: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of	Injury - At home, farm,			28f. Location (Stre	et and Number or Ru	ral Route Number,
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lospit	uners	Medical	29a. Certifier 1 Certifying Physician: To the bes						
the H	hin 24 the F mplet	Me	only one) 3 Certifying Nurse Practioner: To		ge, death occurred at	the time, date and pla	ice, and due to the ca	ause(s) and manner as	stated.
P _C	P		29b. Signature and title of certifier			nse number		d. Date signed (Mont	n, ∪ay, Year)
			30. Name and address of person who completed cause	of death (Itom 20s) (T		003526		4/6/11	
	6		Manuel A Casiana	. , , , , ,	ie, Printi N 74hSt	Fredo	rick, or	10	
	Stat	te	31. Date filed (Month. Day, Year) 32 Box	istrar's Signature	1				
	Registra	ar	APR 0 8 2011	was B.	GOL.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $8^{\text{Day}} 2011^{\text{Ye}}$ Physician/ APRIL 10:00 P M LEACRAFT HASKEW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 □XM 2 □ F Days Min NORTH CAROLINA Director 1923 229-18-3332 87 Usual Residence of Decedent 28a-f show 10a State 10b. County ral", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S DISTRICT HEIGHTS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1215 EDENVILLE DRIVE 20747 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 NoArmy If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 XNo Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6th COMPUTER PROGRAMMER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BENJAMIN LEACRAFT DEALIA JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type, Print) 1215 EDENVILLE DRIVE DISTRICT HEIGHTS, MARYLAND and 2 s Health DOLLIE H. LEACRAFT/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/15/2011 CEDAR HILL SUITLAND, MARYLAND 21. Signature of Funeral Service License J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility Henta 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ aroion Importing Collapse disease or condition Medical resulting in death) Examiner Sequentially list conditions, that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) 1 Live Birth 4 Pregnant 9 Unknown in the past 12 months? Pregnant at time of death Yes 2 No ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 No Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending n 24 hours area when the Funeral Director: After the Funeral filled in by the funerated filled in by t work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Intedical Examiner: On the basis or examination and/or investigation, it my opinion, seaan occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Mu 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CR 10 12150 Amapolis Rd. Ste 200 Glem Dale MID

Registrar DHMH 17 Rev 7/2009

State

Fulako

31. Date filed (Month, Day,

MD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year P^{M} JOHN COOPER April 10:51 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 8. Date of Birth Apr. 20, **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 □ F ^(ear) 1946 Days Hours 213-48-6057 Virginia **Director** 64 Usual Residence of Deceden or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1506 West 9th Street 21702 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married ŏ þ 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" Completed 3 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Management Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bloyce Cooper Lewis Ella Mason Hickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted Lewis / Brother 54 Hornet's Nest Court, Charles Town, WV 25414 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Temation 3 Removal from State 4 Donation 5 Donation 5 Removal from State cemetery, crematory or other place Smithsburg Crematory 4/9/2011 Smithsburg, Maryland 21. Signature of Funeral Se / Le License 22 Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, 1201 NORTH MARKET FREDERICK, MD 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death DISEASE Physician/ ATHERO SCLEROSIS CENERMY Anten disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death page 2 should be detached Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? certificate 1 Yes 2 No ☐ Yes 2 X No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 **X**No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ☐ Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 4795 4-07-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 TOIL HOUSE HUE. MEDERICK 21701 M SATIA MY th, Day, Year) 31. Date filed (Month Registrar's Signature State 1 2 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ APRIL 20^Y9^{ar}1 1:30P **EDWARD** LUPTON JOHNNIE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. MARY 'S CHARLOTTE HALL CHARLOTTE HALL VETERANS HOME Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. OCT. 25, 1929 1**1**₹ M 2 □ F Hours NORTH CAROLINA 242-34-2260 Director 81 Usual Residence of Decedent shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 🔀 No MD CHARLES WHITE PLAINS 10e. Street and Number 10g. Citizen of What Country? Funeral 20695 U. S. A. 7120 BENSVILLE ROAD 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 \sum No If Yes, Give \quad 51 \sum \quad 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 151 - 169 Year or Dates. 1 ☐ Yes 2 No Specify. Specify: WHITE 3 Ma Widowed 4 □ Divorced "natural", other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) U. S. ARMY 5+ COLONEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, be 1 SALLIE (UNAVAILABLE) JOHN A. LUPTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 SAPPHIRE ST. FREDERICKSBURG, VA 22405 JOHN LUPTON/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State APR THE permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State VETS. CEMETERY CHELTENHAM, MD MD 29, 2011 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRAYMOND 22. Name and Address of Facility RAYMOND FUNL. SERVICES, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signalure of Funeral Service 18an M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the a d be detached f g 🗌 Unknown P.O. Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the negrees within 24 hours after death.

To the Funeral Director: After the 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 1 Natural 28c. Injury at 28d, Describe how injury occurred (Month, Day, Year) 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe THOMAS ANNULIS, M.D. 29449 CHARLOTTE HALL RD., CHARLOTTE HALL, MD 20622 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 28 ach Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary F. Monroe 2011 2:40 April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Talbot Easton Genesis HealthCare -The Pines 8. Date of Birth (Month, Day, Yea March 11 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country Maryland 1 □ M 2 🛣 Days Hours 94 Director 221-09-3969 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 □ No Easton Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 610 Dutchman's Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Trucking Industries Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Mabel Huhn Francis D. Zaffere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3024 Choptank Rd., Preston, MD 21655 John Monroe/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/07/11 Federalsburg, Hill Crest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. . Signature of Funeral Service Licenses Michael Federalsburg, MD 21632 216 N. Main St., Approximate Interval Betw 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each Onset and Ceat Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last ned by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempleted filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

MDHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ Month 11:00 Flora Marta Maden April 9 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Cardenas 1 🗌 M 2 🔀 F Days Hours Min. 577-84-0595 86 Director March Cuba Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🛛 Yes 2 🗌 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4104 Nicholson Street 20782 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or þ 1 X Never Married 2 Married ☐ Yes Yes, Give 2 X No Maryland 21215-0036 If Yes, 1 X Yes 2 ☐ No Specify: Cuban Specify: Hispanic Completed 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Sebastian Maden Valentina Morales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria A. Lopez / Daughter 4104 Nicholson Street, Hyattsville, MD 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/16/2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complestions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami and ul-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy certificate 2 🗌 No 1 Yes Yes 2 N **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 \square Yes 2 7 မ ER/Outpatient 3 🗀 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending nours after death.

neral Director: Aft
filled in by the fur Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the pasis of examination and/or investigation, in this popular, decard occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the F only one) 29b. Signature and title of certifier rson who completed cause of death (ton 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5^{Day}2011 Physician/ APRIL 11:25 PM LOUISE MCNEILL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death HYATTSVILLE PRINCE GEORGE'S HEARTLAND HEALTH CARE CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 28 1923 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 1 □ M 2 🕸 Hours Director 246-24-6477 NORTH CAROLINA Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S COTTAGE CITY MD or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 3706 37th AVENUE 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 2 X No 1 ☐ Yes 2 🔀 No Specify: If Yes, Give BLACK "natural" 3 Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygier is marked other t 12TH SALES SUPERVISOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည STERLING RUFFIN BESSIE JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a WEST RIVER, MARYLAND 20778 KENNETH MCNEILL/SON 5331 SWEET WATER 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 4/12/2011 LANDOVER, MARYLAND HARMONY CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Int r the di shock, br eart ai Immediate Cause (Fi ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Onset and Death Physician/ ARTHEROSCLEROTIC CEREBROVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by SACRAL DECUBITUS ULCERS Records, 1 Yes 2 No 3 Probably 4 L Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page Yes 2 X No 1 Yes 2X No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital ᄵ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number filled in by determined 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State
Registrar

State 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 3 2011 32. Registrar's Signature APR 1 3 2011

LESTER MILES M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of ertifie

29c. License number

D0026024

1160 Varnum Street, NW, Washington, DC 20047

29d. Date signed (Month, Day, Year) 04/08/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 2:18 A M Leonard Michael McGinn April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick 9. Birthplace (State or Foreign Country) Minnesota Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 66 Director 474-48-6417 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2XXNo Maryland St. Mary's Charlotte Hall 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Rd. 20622 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. the Martinal Evantina 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Supply Clerk U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Joseph William McGinn Elizabeth Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Dunigan/Sister 2608 South Paddock, Wasila, AK 99654 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem! 04/19/2011 Cheltenham, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signaturetof Funeral Service Licenses β0195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Aspiration disease or condition resulting in death) eumonia Medical as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dysphogio 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen Hypeortensive Cardio Vasular directe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 🗌 No 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital Other: မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Mor

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Churutan

Registrar's Signat

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Road Deale

2075

yun -c

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 19^{ay} Cora Elizabeth Meridith 2011 4:59 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Nursing Center Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea Months Days Hours (ear) 214-60-3456 87 Director Sept. 1923 Maryland Usual Residence of Decedent 28a-f show 10a State 10c, City, Town or Location 10d, Inside City Limits with the Maryland be notified at Director Maryland Charles Charlotte Hall 1 ☐ Yes 2 🛣 No 0 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 23a 9590 Meridith Road 20622 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married b altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester Oliver Daisy Frogmartin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Meridith/Son 39393 St. Thomas Drive, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State matory or other place) April 20 Brinsfield-Echols Crem. Charlotte Hall, MD 4 Denation 5 Other (Specify) re of Funeral Service Licenses 21. acm t 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MO0817 MD 20622 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 movins?

1 Yes 2 No 23d. Date of delivery õ Pregnant at time of death 4 ☐ Pregnam g ☐ Unknown this certificate has been signed by the and director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to hedical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \quad Yes 27. Manner of Death 28b. Time of Certificate: 28d, Describe how injury occurred After injury 1 Natural 5 Pending 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 3 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uite IA, Annopolis Colone 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

11-02528 Jeffrey A. Martin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

епгеу А. Мапіг	•	State of Maryland / Department of Health and Menta 1-For State Certificate of Death	al Hygiene 2011 13596
Physici		n/ 1. Decedent's Name (First, Middle,Last)	Date of Death Month Day Year October 1
ledical Exami	iner	Jeffrey A. Martin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	April 2, 2011 0945 nrs
Ž.		7204 Bowers Road Frederick	Frederick
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea	24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign West Country) Virginia
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
È .,	'n	Maryland Frederick Frederick	1 Yes 2 No
the Maryland a or 28a-f show	Director	10e. Street and Number 10f. Zip Code 21702	10g. Citizen of What Country? USA
3 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ral Examiner must be notified at once	by Funeral	Wildowed 4 XX Diverged If Yes Give Year	
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	ompleted b		se retired)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Com	O 17. rather's Name (First, Michael, Lasty)	Name (First, Middle, Maiden Surname) en Archer
MD 21 d 2 should I th and Mer n 27 is man	To	Janet Trueman - ex-wife 19b. Mailing Address (Street and Numb	per or Rural Route Number, City or Town, State, Zip Code) Court, Frederick, Maryland 2170
Baltimore, MD 21215 permit Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked or injury or other traumatic event, the		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Stauffer Crematory	Date 20c. Location - City or Town, State 4-8-2011 Frederick, Maryland
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtow	Stauffer Funeral Home vn PIke, Frederick, Maryland 21
Physician v dita xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Between Onset and
K.F.	L	Sequentially list conditions, b	
sd Sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting injury that initiated event	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	23d. Date of delivery pregnancy Month Day Year
i, P.O. Baires that the designed by the	ğ	à	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, ng Physician: The law require the this certificate has been si neral director, page 2 should b	Completed		24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rectant The	Be Co	b 25. Was case referred to medical 26. Place of Death (C	
f Vit Physic er this c	၉	O 1 ✓ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 I	Nursing Home 5 Residence 6 V Other Scene 28d. Describe how injury occurred
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Division pital or Attendiours after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide (Si)ecify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours To the Funeral	Medical C		re, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
P a F S	M	29b. Signature and after of dertifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 3, 2011
1		30. Name and address of person who completed cause of death (Item 23a) Mary G. Rippie MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimor	re, MD 21201
St	ate		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2011 JoAnn McCraw 0030 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 42 Queen Eleanor Drive E1kton Ceci1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** g. Birthplace (State or Foreign Hours DEC 15, Year 946 1 □ M 2 🛱 F Director 219-44-5440 64 Yrs Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ceci1 1 🗆 Yes 2 🗶 No Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 42 Queen Eleanor Drive 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Inspector Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental ant: If item 27 is marked o ည William B. Bouchelle Gladys Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. McCraw/Husband 42 Queen Eleanor Drive, Elkton, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 20. Cherry Hill Methodist Cemetery Methodist Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Cherry Hill,</u> 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ cancel disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) -transit law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 Unknown 2 No the detached 9 Unknown is been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 🗌 Probably 4 🗌 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Hospital or Attending Physician: The I
 24 hours after death.
 Funeral Director: After this certificate h perform 1 Tes 2 No of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 5 Pending Division 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. address of person who completed cause of death (Item 23a) (Type, Print) nmers Run RD, Baltimore, MD 2122

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Fletcher Jean McNew 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death omic bι 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 KM 2 🗆 F Sept. 16,1932 Months Virginia Director 231-36-1736 78 Usual Residence of Decedent or 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director MDDorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 409 Atlantic Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Ves 2 No If Yes, Give 1950-54 Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) stee1worker steel mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Frank McNew Edgar Alice Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan McNew wife 409 Atlantic Ave., Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of Delmarva 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4/13/11 Delmar, DE 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ LUNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X10 Yes 2 🗹 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2/1 No Other: 1 🗌 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICZ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation within 24 hours after des To the Funeral Directol completed filled in by th ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 | Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21002 Ce Hayan 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend 10g per FD, DOR, Registrar4/13/11, LDB Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last, 2 Date of Death Month Physician/ Year 201 meekins AIVIC 01:15 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Battimore Maryland medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Country) 1 MM 2 - F Months Hours **Director** Usual Residence of Deceder items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Examiner must be notified 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ö þ hours after Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced "natural" W Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a Informant's Name/Relationship (Type, Print) 3/1 MD 2/6/5 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of or Town, State Location Date cemeters crematory or other place 1 Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service License any f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Patteremio disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant
9 Unknown signed by the a d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnods been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy has certificate 1 Yes 2 No Yes Hospital or Attending Physician: To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital: Other: ဍ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 2 | No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2011

State Registrar 31. Date filed (Month, Day, Year)

APR 13 2011

Baltimore; mp

Plane and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

SYSTEMS 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 8602 RAPLEY GATE TERRACE, POTOMAC, 20c. Location - City or Town, State BARNESVILLE, MD BOX 86 BARNESVILLE. Approximate Interval Between Onset and Death
19 MONTHS 23d. Date of delivery Dav 23e. Did tobacco use contribute to the cause of death? 1 🔀 Yes 2 🗌 No 3 🗋 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year, APRIL 6, 2011 036121476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 KARAMA. ORIGINAL

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IISA

Black, White, etc.

7:45 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Bintrip: Country) NJ

20

State

Registrar

				ase Type or Pri					_	_	jible.	
		Tor #26 Amended State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar ER bbk 4/13/11 Certificate of Death Reg. N. 20 370						13701				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					Month Day Year			3. Time of Death	
	Medic	al		rothy Christ	ine N	<u>liblet</u>	1					2:05 a _M
	Examin	iner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY						MICO				
	Funeral Director		5. Social Security Number 6. Sex 1					th y, Ye <i>ar)</i> 1942	9. Birthp Count Nor	place (State or Foreign try) th Carolina		
	nd how at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	//aryla 8a-f s tified	Director	Maryland Some	erset	Ede	en						1 ☐ Yes 2 🏝 No
	a or 2 be no	ał Di	10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?			itry?
	th with ms 23 must	Funeral	14405 Dogwood			lan i	2182			US		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If time ZT is marked other than "natural", or items Z3a or Z8a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status1 ☐ Never Married 2 Mar3 ☐ Widowed 4 ☐ Divorced	If You Give			Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 X No		Rican, etc.)	14. Rad Blad	e - Americ ck, White, e	
2-0	2 hour "natu dical	plet		nt's Education est grade completed)		16a. Deced	ient's Usual Occup	ation during most of work	kina	16b. Kind of B	usiness Ind	dustry
2121	within 7% giene. er than , the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. D	ONOT use retired) ant Hous			r Nur	sing	Home
land	l be filed lental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, B Raymond Bobby					18. Mother's Nan Marth a	ne (First, Middle, a.C. ACC		e)	
Baltimore, Maryland 21215-0036	id 2 should salth and IV n 27 is ma er traumat		19a. Informant's Name/Relations Philip E. Nible			19b. Mailir 1440	ng Address (Street) 5 Dogwoo	and Number or Rui	ral Route Numbe den, MD	r, City or Town, S 21822	State, Zip C	Code)
imore	Page 1 an nent of He ant: If iten .rry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (\$		20b. Pla	ace of Dispo metery, cren 'indhi irdens	sition (Name of patory or other place) Memory	^(e) 4/1	Date 4/2011	20c. Location Hebro	•	
3alti	ermit. Departr nports ny inju		1. Signa ure of Fu leral Service I	_icensee					Home Pro	fession	al As	sociation 4
	<u> </u>	10 0	23a. Part 1. Enter the disease, or	r complications that caused	the death						2180	Approximate
١,	กับรายาลกับ	8 0	shock, or heart failure. List of Immediate Cause (Final	only one cause on each line	- 11				4			Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as a	n ५// a conseque	ence of):	Carcino	ma ct t	The LU	^9		Zmos,
	Examiner	Į.	Sequentially list conditions,	b							_	
	ted nsit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to or as a	conseque	ence on:						
	e executed lan and unal-transit		that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):						
9	ate be	dice		d		_						
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death of the within 24 hours after death of the charental Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the completed filled in by the funeral director, page 2 should be detached for use as the but the but the properties of the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 屬 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		1	ate of delive	ery Day Year
P.O.	that the	by Ph	Part II. Other significant condition				inderlying cause gi	ven in Part I.	23e. Did te	obacco use cont	ribute to th	ne cause of death?
ds,	quires en sign ould be		Anemia	profic vasco	1				1 027	Yes 2 ☐ No	3 🗌 Prob	oably 4 🗆 Unknown
Secor	he law re rte has be rage 2 sho	Completed	Atheroscle	rotic vasci	ular	Dr.			perfo	a. Was an autopsy performed? ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ Ye		mpletion of cause of
a	ian; T ertifica ctor, p	Be C	25. Was case referred to medical examiner?					iace of Death (Chec		2 44 1101		
<u> </u>	Physic this ce al dire	ျှ	1 🗆 Yes 2 🔀 No				nt 3 🗆 DOA Oth	4 ☐ Nursing H	lome 5 X Residence 6 ☐ Other (Specify))	
on o	ending F sath. or; After i he funera	Certificate:	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi	igation	ry v, Year)	28b. Time of injury	work		28d. Describe h	now injury occur	red	
Division of Vital Records,	tal or Atturs after de al Directo ed in by t		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ				eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	he Hospi in 24 hou he Funer ipleted fill	Medical	(Check 2 Medical E	g Physician: To the best of Examiner: On the basis of ea g Nurse Practioner: To the	xamination :	and/or invest	tigation, in my opinie	on, death occurred	at the time, date a	and place, a <mark>nd d</mark> u	e to the ca	use(s) and manner stated.
	To t with To tal		29b. Signature and title of certified	J. Im	10		29c. Licens	e number		29d. Date signe	d (Month, i	Day, Year)
-	(be)	6	30. Name and address of person Robert J. 1	who completed cause of de	eath (Item 2	23a) (Type, F			lisbury	m1.7	1801	
	Stat		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ire par	Print) Side Or.			1.0.1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 15 Day 20 Î Î Jean Kathryn Runk O'Day 3:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Chesapeake Shores Lexington Park Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Delaware 1 □ M 2 **X** F Min. oct. 13 ^{Yea}r 923 Director 221-16-9434 87 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22680 Cedar Lane Court Apt. 1231 20650 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: White Specify. 3 X Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mential Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles R. Runk Ruth Jefferson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2170 Stephen O'Day / 23812 Meredith Court; Hollywood, Maryland 20636-20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State Greensboro Cemetery Apr 19 2011 4 Donation 5 Other (Specify) Greensboro, Maryland 22. Name and Address of Facility
'leegle and Helfenbein Funeral Home, PA
PO Box 160; Greensboro, MD 21639 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cath Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 No ☐ Yes 20 N 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Hatural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) completed filled in 24 hours Medical 1 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pranticeer: To the best of my knowledge death occurred at the time date and place, and due to the within 2 To the I

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certi

31. Date filed (Month, Day, Year)

Amir N. Alikhani,

APR 2 U 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD:

2. Registrar's Signature

4604

101 Centennial Ave. LaPlata, MD 20747

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Year 2011 Physician/ 1451 Barbara Jean Olsen 11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Days Hours Min. (Month, Day, 56-34-9865 **Director** 70 Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2🔀 No NJ Bergen Glen Rock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 198 Fairmount Ave. 07452 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ₩ Widowed 4 Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Education other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ည Everett Walker Frances Lander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric L. Olsen High Sheriff Trail, OCean Pines, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If i any injury or c cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State First State Crem. 4/14/2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opeet and Death Immediate Cause (Final ASCUD Physician/ disease or condition , Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death g Unknown a 🗌 Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director; After this certificate h completed filled in by the funeral director, page 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Vital æ 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 은 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. dentifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and ti 29d. Date signed (Month, Day, Year, 1150497 4/12/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salibar BA 25 hris Do. ME PO E Carroll St. egistrar's Signature State MARCHA Registrar

Bobarc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRTL FRANCIS VERNON PROCTOR 2ÖÎ'1 1:50 P M Medical 4b. City, Town, or Location of Death a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner CHARLES RESIDENCE. 104 CHARLES PLACE INDIAN HEAD . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 X M 2 🗆 F NOVEMBER 10, 1953 Yrs MARYLAND 57 Director 217-60-8278 Usual Residence of Decedent 28a-f shov within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1 X Yes 2 No INDIAN HEAD MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 CHARLES PLACE 20640 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than than 12TH GRADE College (1-4 or 5+) MAINTENANCE WORKER FEDERAL GOVERNMENT Hygier other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o MORRIS PROCTOR ELIZABETH AGNES SAVOY PROCTOR traumatic Department of Health an Important if item 27 is no any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 MATTAWOMAN COURT, INDIAN HEAD, MARYLAND 20640 SHANELL M. PROCTOR / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State ST. JOSEPH'S CHURCH CEM. APRIL 15,2011 POMFRET, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) LIDLA C. THORNTON JOHNSON MO0583 THORATON FUNERAL HOME, P.A 3439 LIVINGSTON ROAD, INDI INDIAN HEAD. MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lip. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner If any leading to inniscrate cause. Enter Underlying Cause (Disease or linjury that initiated events Dun'to (or es a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manaer of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be within 24 hours at er dear To the Funeral Director completed filled i⊨ by th∈ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a Medical 29a. Certifier A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29 c. License number 29d. Date signed (Month, Day, Year)

285

State Registrar R. TIMOTHY PACE, M.D. 12070 OLD LINE CENTER, SUITE 302, WALDORF, MARYLAND 20604

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 1 2011 32. Registrar's Signature

D22574

APRIL 11, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :34 P M WILLIAM AUSTIN PERRY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Hemoria Talba Social Security Number 9. Birthplace (State or Foreign Country) MARYLAND If Under 1 Year If Under **Funeral** 7. Age (In yrs. last birthday) 24 Hrs. 8. Date of Birth Days Min. 1 X M 2 🗆 F JULY 11, Year) Director 60 215-50-0407 Usual Residence of Decedent 28a-f show 10a, State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29292 HICKORY RIDGE ROAD 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married ğ 1 ☐ Yes If Yes, Give and 2 should be filed within 72 hours after Health and Mental Hygiene. 2 **X** No Maryland 21215-0036 1 ☐ Yes 2 K No Specify: WHITE Completed 3 Divorced 4 Divorced Specify: Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 CONSTRUCTION CARPENTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ WILLIAM ARTHUR PERRY ELIZABETH HADEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 27 is r 21601 29292 HICKORY RIDGE ROAD, EASTON, MD Page 1 and 2 BRUCE H. PERRY, BROTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o Department of ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION 4/8/2011 STEVENSVILLE, MD 4 Donation 5 Other (Specify) . Signa 2. Name and Address of Facility ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, OO SOUTH HARRISON STREET, EASTON, MD 216 21601 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he each line. 23a. Part 1. Enter the disease, or complication Approximate Interval Between shock, or heart failure. List only one caus Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Due to (or as a consequence of): Medical **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 1 🗌 Yes 2 No 2 - No 25. Was case referred to ____ical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hame 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner eath 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type I fint) 30. Name and address of /eglséder 503 CYNWOOD DRIVE, EASTON, MD 21601 LUDWIG J.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month Da

08

2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month Physician/ 19:20 P M 8 April Elzavan Urell Plunkett Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign Country)
North Carolina 5. Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year 8. Date of Birth **Funeral** 1 X M 2 A F Months Days Hours Min (Month, Day, Year 76 **Director** 245-48-1833 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 X Yes 2 No Capitol Heights Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ritems 23a or ner must be n Funeral 4105 Southern Avenue Apt. 4B 20743 United States death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, the Medical Examiner Armed Forces?

1 X Yes 2 No ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify 3 Widowed 4 Divorced Completed American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Entrepreneur permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မှ John Wesley Plunkett Alice Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandria, VA 6810 Morning Brook Terrace James R. Weeks - Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Presbyterian Ch Cemt. 1 X Burial 2 Cremation 3 Removal from State 1 15, 2011 Concord, North Carolina 4 Donation 5 Other (Specify) 21. Signal 12 of Funeral Service Licer 22. Name and Address of Facility Stewart Funeral Home, Wto 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final SEPS15 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant : g ☐ Unknown Pregnant at time of death the signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? <u>}</u> DISFASE OBSTRUCKIVE PUL MONARY 1 Yes 2 No Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? FAILURE 24a. Was an CONGESTIVE has page 2 autopsy 1 Yes 2 No this certificate Yes 2 No e Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1♥ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Man of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one) 29b. Signature and tit e of certifier 29d. Date signed (Month, Day, Year) 4/11/201 D0064986 ONWUKA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CR 5 Suite 304 Glen Burnie, Maryland 1406B Crain Hwy S Chike G. Onwuka, MD

State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year,

APR 1 3 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ APRIL PRIDGEON 7:55 P M LOIS Α. 11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Funeral Age (In yrs. last birthday) 1 DM 2 X Days Hours Min. JULY 9 1947 INDIANA Director 313-50-3003 63 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1613 VILLAGE GREEN DRIVE 20785 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien ris marked other tl HAIR STYLIST PRIVATE 9TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ WHARTON WALTER HELMIC MAREL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra TIMOTHY E. MCCOY/SON 530 HAWTHORNE AVENUE ANDERSON, INDIANA 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 D Removal from State BIVERDALE CREMATORY 4/14/2011 RIVERDALE, MARYLAND 4 Donation 5 Other (Spe. 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Acensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 13 tions that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause or each line. 23a. Part 1. Enter the Season, shock, or heart reliure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been si le 2 should l 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha irector, page performed death? 2 1 No 2K No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 2 3 100 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completed filled in by the funera Hospital or Attending 1 Natural injury work? 1 🔲 Yes 5 Pending 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ April 1:13 A M 11 Marie Teresa Perry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Prince George's Clinton 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 🛣 Months Days Hours Min 08/15/1921 Pennsylvania 89 Director 176-18-3870 Usual Residence of Decedent show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Temple Hills Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 USA 2708 Keith Street death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 **X** Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) lementary/Seconday (0-12) College (1-4 or 5+) Switchboard Operator U.S. Treasury 12 years n and Mental Hygien traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ann Carey Martin Lyons rmit. Page 1 and 2 should be partment of Health and Mer portant: If item 27 is mark, y injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 20748 2708 Keith Street Temple Hills, Maryland John Perry Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State Unk. 4 Donation 5 Other (Specify) Arlington Nat. Cem. Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Funeral Service Lice 21. Signature Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir the burial-transit and resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) atter Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Year Month Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s certificate has performed 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural injury 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier

CR 8

State Registrar

DHMH 17 Rev 7/2009

address of person who completed cause of death (Item 23a) (Type, Print)

COTSICY AND 12070 PUD LINE (CATER WAUGHT,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Day Persinger 9:00 AM Virginia Mae 04 5 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Julia Manor Health Carel send ter Washington Hagerestown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 X F Days oct. 2,1927 Min. 220-26-5103 83 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County 1 Yes 2 □ No Hagerstown 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. Julia Manor Health Care Center 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 3 X Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isadora M. Haines Wilhelm Carter Luther Paul Wilhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Norris-daughter 135 West High St. Hancock, MD 21750 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date per nit. Page 1 a
Der artment of H
Imr ortant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 4-16-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Kaitlin 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the d. e. e, rr omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Du H (or as a consequence of): Physician/ 2 vice ust 13 Heart disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of nding physician and use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 No 3 Probably 4 Unknown Asthma Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 4 hours after death. uneral Director: After of filled in by the fun 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier within 24 hor To the Fune completed fil Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R125360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 333 Millistreet, Hoberstown, MARyland 21740 JH-5 Barbaro 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Box 68760

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :170M Medical 4a. Facility Name if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death Center ave Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 K F Months Hours (Month, Day, Ye **Director** or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 No 10f. Zip Co 10g. Citizen of What Country? YUMan 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Completed by Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) anning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 01 Ke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark 00 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 15 21. Signature of Funeral Service Licensee 22. Name and Address of Facility uneral Shi HUME, HENRY death. Do not enter the mode of dying, such as cardiac or respiratory arrest 510 W 23a. P at 1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each fine. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ A disease or condition CAC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 d for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 m Month Day signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifics 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Certificate: To Be 26. Place of Death Check only one Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Pesidence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 L Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif who completed cause of death (Item 23a) (Type, Print) Bratible 100

DHMH 17 Rev 7/2009

State Registrar 31, Date filed (Month, Day, Year,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20ÎÎ 10:30 PM Grace E. Paul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville Summit Park Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏋 🛚 Hours Months 06-25-1920 90 NC Yrs Director 238 05 0534 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21043 United States 4008 Cooks Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married by Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Mae Simpson William Hamilton Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21075 5934 Setter Rd. Elkridge, MD Gary Roberts/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crem. Svc. 4-13-2011 Hanover, MD M0104422. Name and Address of Facility Harry H. Witzes Family FH Inc. 21. Signature of Funeral Service Licensee Gell 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter un mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and a be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4X Nursing Home 5 A Residence 6 Other (Specify) Hospital: 2 🕱 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending injury 1 XNatural 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only/one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 04-13-2011

Registrar

State

30. Name and address of

4 201

ompleted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT J. OUEEN APRIL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death STELLA MARIS TIMONIUM 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Days Min. Hours Months Director 215-62-3071 Yrs 58 Usual Residence of Decedent 28a-f shov 10a. State 10h County notified at 10c. City, Town or Location Director MD ANNE ARUNDEL LAUREL ò 10e. Street and Number 10f. Zip Code Examiner must be items 23a Funeral 231 BROCKBRIDGE ROAD 20724 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No "natural", or 1 Never Married 2 X Married Completed by 1 Yes
If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PAVER OPERATOR 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ STEPHEN QUEEN DOROTHY 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONITA QUEEN / WIFE 6111 SEABROOK ROAD, LANHAM, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State APRIL 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEM. PARK 4/13/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, 7474 LANDOVER ROAD, HYATTSVILLE, MD Part 1. Enter the disease, or complications that caused shock, oneart failure List only one cause on each line. 23a. Part 1. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition resulting in death) STOMACH CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 24a. Was an or Attending Physician: The law After this certificate has page perform To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at X Natural 5 Pending injury work? Accident Suicide Investigation М 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and t 29c. License number who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death 2011 1:00 a M 4c. County of Death BALTIMORE 9. Birthplace (State or Foreign MAY 4, Day, Year) 2 MARYLAND 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? US Race - American Indian. Black, White, etc. Specify: BLACK 16b. Kind of Business Industry AGGREGATE INDUSTRIES HAT.T. 20c. Location - City or Town, State LANDOVER, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes HOSPICE 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 201 TIMONIUM, MD 21093

State Registrar JACKIE JONES.

Mon

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 0800A M **JESSIE JAMES** RAYNE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UKOMK Comai If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 Å M 2 □ F Days Hours Min. AUG 04, Year) 221-28-9734 66 DELAWARE Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehroren injury or other traumatic event, the Madiral Economics. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director DELAWARE SUSSEX COUNTY LAUREL 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19956 504 LITTLE CREEK DRIVE UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married If Yes, Give Year or Dates. 1965–91 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) MILITARY CAREER SOLDIER, US ARMY 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMMY ည GRIFFIN GRACE RAYNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY RAYNE (WIFE) 9747 HOTEL RD., BISHOPVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State APR 11,2011 DEL. VET. MEM. CEM. MILLSBORO, DE 4 Donation 5 Other (Specify) Funeral Service Lice 22. Name and Address of Facility WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE MO 1361 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Nourran a Medical Due to (or as a consequence of): **Examiner** Medical Certificate: To Be Completed by Physician/Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, To the Funeral Director completed filled in by the

within 24 hours a

State

Registrar

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o off:	ructive Pul	_	Nicorac				
Cause (Disease or iinjury that initiated events	· Chronk Obst	ructive lul	Monary	Disease				
resulting in death) Last	Due to (or as a consequence of):		1					
	d							
IF FEMALE:				,				
23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ec	stopic pregnancy		23d. Date of delivery				
 in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	In the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day Year							
Part II. Other significant conditions of	contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?				
			1 ☐ Yes	2 No 3 Probably 4 Unknown				
	no profile		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
			performed					
25. Was case referred to medical examiner?		26. Place of Death (Check	(only one)					
1 XYes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3	Other:	me 5 Residence	6 Other (Specify)				
27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury 28b. Time of injury injury	28c. Injury at work?	28d. Describe how in	jury occurred				
2 Accident Investigatio	on	M 1 Yes 2 No						
3 Suicide 6 Could not to 4 Homicide determined	" 1996 Place of Injury - At home form street	factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	building, sto. (opeony)		Gity Or TOWN, Ste					
	ysician: To the best of my knowledge, death occu							
	niner: On the basis of examination and/or investigat rse Practioner: To the best of my knowledge, deatl							
29b. Signature, and title of certifer		29c. License number	29d.	Date signed (Month, Day, Year)				

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2011 Physician/ Robinson 6:30 AM Eugene Reginald Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 7 1960 r 7, 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Days Hours Min Washington, D. C 579-92-6056 December 50 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location death with the Maryland Director 1 X Yes 2 No Washington District of Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Funeral 20018 2504 - 10th Street, N. E.; Apt. 406 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 Yes 2 X No Black, White, etc. 1X Never Married 2 Married þ Maryland 21215-0036 within 72 hours after **Black** 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Divorced 4 Divorced the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Apartments Building Building Maintenance Worker 7th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mack မ Thelma Louise Eugene Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 - 10th Street, N.E.; Apt. 406; Washington, D.C. 20018 Pamela Lolita Mack (Sister) Baltimore. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of April 15. cemetery, crematory or other place) 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Washington, D.C. Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Sonature of Funeral Seg 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ CARDIO DISMONORY disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions or any leading to immedicause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): PKOKED BY Physician/Medical Box 68760 the. nding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Po Month Pregnant at time of death ed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 🗀 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death?
1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Yes မ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) of 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Regis

Physician/ Medical Examiner 1. Decedent's Name (First, Middle, Last) JOANNE RILEY 4b. City, Town, or Location of Death Charles WALDORF Funeral Director 5 Social Security Number 6 Social Security Number 7 Social Security Number 8 Social Security Number 8 Social Security Number 9 Social Security Number 10 Social Security Number		-	Please T State Registrar Amend #5 pe	State of Ma	ryland / Dep	artment of H	lealth and M	All Copies A Mental Hygie Reg.	ne 2011	13717						
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Secretary of the control of the co			<u>578-70-5579</u> 1□	M 2X F				8. Date of Birth Month, Day, Yea MARCH 3								
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Baltimore, Maryland 21215-0036

Box 68760 C Division of Vital Records.

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Baltimore, Maryland 21215-0036	be filed ental Hy ked oth ic event	To E	17. Father's Name (First, Middle, Last) Otis Roberts 18. Mother's Name (First, Middle, Maiden Surname Emily Boyd						10)			
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	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	<	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date signe			
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S	N-3+1		30. Name and address of person w	the completed cause of de		ype, Print) 110 N	reducal	Campis	Hz	enh	un MD.	
	Sta Registr		31. Date filed (Month Dry Year)		r's Signature	Sou						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 12 2011 STACEY KTM ROUGHTON 3:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MED. CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2**X**] F Months Hours 19<u>66</u> MARYLAND **Director** 45 215-84-5432 MAR Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD CALVERT NORTH BEACH 1 X Yes 2 No P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 3810 OAK STREET 20714 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2X Married within 72 hours after Maryland 21215-0036 nan "natural", Medical Exan 1 ☐ Yes 2XXIIo Specify 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) the CAR DEALERSHIP 12 SERVICE MANAGER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ೭ ELTON PADGET FRANCES DODSON ige 1 and 2 should be nt of Health and Men ∷ If item 27 is marke traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH ROUGHTON / SPOUSE 3810 OAK STREET NORTH BEACH, MARYLAND 20714 Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ö Department of Important: If any injury or once. TRINITY MEM.GRDNS. 23, 2011 WALDORF, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Lew 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the k as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page death? certificate l 2 No Yes or Attending Physician: after death. 25. Was case referred to edical Be 26. Place of Death (Check only one) Hospital Other: 2 🖪 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 V Natural injury 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Anne HOWARD

State Registrar Date filed (Month, Day, DR 28 2011

egistrar's Signature

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			Decedent's Name (First, Middle,	Last)					2. Date of De	eath		3. Time of Death	
	Physicia Medic		Victor	Ian		Ro	stuart,	Sr.	Apri	1 1 ^D	1 2011	7:15 A ^M	
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-	<u></u>		Berlin Nursing 5. Social Security Number		== /l= 1/12 lan	at faireth -tour	Ber If Under 1 Yea	lin ar If Under 24 F	re O D-t- of D	-41-	Worceste		
	Funeral Director		181-24-0551	1 X M 2 □ F	ge (In yrs. las	Yrs.	Months Day			rth ay, Year) TO 22	9. Birthp Count	lace (State or Foreign ry) Svlvania	
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	Maryland 28a-f show otified at	cto	10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits	
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	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		5801 Argyle Driv 11. Marital Status	12. Was Deceden	Ever in U.S.	13. \	Vas Decedent of	21849 Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	-	USA 14. Race - America	an Indian.	
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215-0036	urs af tural" al Exa	Completed	3 🕅 Widowed 4 🗆 Divorced	Year or Dates.	194.	5	☐ Yes 2 🔀 N	чо Ѕреспу:			Specify: Whi	te	
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Roystuart , Maryland 2	permit. Page 1 and 2 should re filed within 72 hours after death with the Maryland Department of Health and Intertal Hygiene. Important: If item 27 is minited other than "natural", or items 23a or 28a-f sho any injury or other traum: tic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	(Type, Print)	·	19b. Mailir	g Address (Stree	et and Number or	Rural Route Numb	er, City o	r Town, State, Zip C	(ode)	
So. So.	and 2 Health em 27 ther tr		Deborah Timmons	- Daughte:				Road, I			Maryland		
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/ic Ba	permit. Departr Imports any inju		21. Signature of Funoral Service Lic	bill R	nho	1	. Name and Add	•	Bounds F	_	al Home , Marylar	nd 21804	
	-		23a. P. 1. Enter the disease, or c shock, or heart failure. List on	omp tions that cause	ed the death.						, mary tar	Approximate	
	Physician/		Immediate Cause (Final	y on cause on each li	ne.	054	100 h	rood				Interval Between Onset and Death	
€	Medical	Ш	disease or condition resulting in death)	au_to (or a	s a conseque	nce of):	COX C	New -				·-	
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376	Attending Physician: The law requires that the death certificate or death. externing the steer this certificate has been signed by the attending physicy the funeral director, page 2 should be detached for use as the	/ledi		u								-	
39 ×	endin	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1						- 13	23d. Date of delive	ery		
Box 6876	e death the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant 9 Unknown	at time of de		Other (specify)				Month	Day Year	
P.O.	that the de ned by the detached	Completed by Physician/Med	Part II. Other significant condition			ting in the u	nderlying cause	given in Part I	23a Did	tobacco	use contribute to th	a cause of death?	
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	e Hos 124 h e Fun eleted	Medical	(Check 2 Medical Ex		examination a	and/or invest	igation, in my opi	nion, death occurr	ed at the time, date	and place	e, and due to the cau	ise(s) and manner stated.	
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	1		1 (Ilnne)	avagn	K/U)		R	135131		Apr	il 11, :	2011	
	170		30. Name and address of person wi				,						
	INA		Pennie Savage 31. Date filed (Month, Day, Year)		9715 rar's Signatur		thway I	Dr., Be	rlin, M	D	21811		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Amend Item 19a per fh,g918,08/23/2011dhb
Registrar FH, TCHD, pha 4/7/11 Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 0453 April Denise tanlex 201 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** labot Easton Memorial Hospita 8. Date of Birth (Month, Day, Year) 04-20-1966 Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 F Months Hours Director Pa. 215-74-1646 Usual Residence of Deceden 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director Md. Caroline 1 Yes 2 No Federalsburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral Harper Road 21632 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc ò 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene Child Care 12 Baby Sitter Stanle Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julia Butler Walter Nickerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 21632 Vanessa Hughes <u> 2913 Harper Road, Federalaburg, Md.</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Lisa Date 5 1 X Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) 04-09-11 Federalsburg, Md Bethel Cemetary Name and Address of Facility Bennie Smith Funeral Home 21. Signature of uneral Service Lic any Main Street, Hurlock.Md.21643 516 23a. Part 1. Enter the disease, or complications that caused me ath. Do n enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (sequence of) Due to (or as a n Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) been signed by the should be detached briknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed? death? 1 ☐ Yes 2 ☐ No 1 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: မ 1 Yes 2 No Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1- Natural work?
1 Yes 2 No 5 Pending injury 2 Accident
3 Suicide Investigation after death Director: 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur nd title of certifle 5656 30. Name 31. Date filed (M Registrar's Sig State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No._ Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2011 OX Mohammed)hamsi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 16 Days 4 UNITE NONE **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director ABUDHAB 10g. Citizen of What Country? 10e. Street and Number 50 NONE ZAKHE 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: WHITE ş 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) EDUCATION and Mental Hygiene. STUDENT 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be SHAMSI ALIAZI SALEM AL MOHAMEN ٥ 19a. Informant's Name/Relationship (Type. Print) FATHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 SAEED SALEM AL SHAMSI injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State TAB1 U.A.E 4/15/2011 ABU DHABI U.A.E

22. Name and Address of Facility ADEN MUSLIM FUNERAL SER ABU DHABI ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 7-DEN MUSLIM FUNEA

Approximately 7-DEN MUSLIM FUNEA Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specity) 2 🗌 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 2 X No 1 X Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Injury 1 X Natural s after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address JAMC 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State 3 2011 APR 1 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 5 2011 8:25 P MARIE SATTERWHITE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death PRINCE GEORGE'S PRINCE GEROGE'S HOSPITAL CHEVERLY Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours JULY 9 1943 NORTH CAROLINA Director 67 245-64-9409 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director UPPER MARLBORO PRINCE GEORGE'S 1X Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 HERRINGTON DRIVE 20774 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) econday (0-12) College (1-4 or 5+) GOVERNMENT OFFICE PERSONELL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SUSIE LEE HORN FOUNTIAN ARCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NATHANIEL P. SATTERWHITE/HUSBAND 100 HERRINGTON DRIVE UPPER MARLBORO, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State FT. LINCOLN CEMETERY 4/16/2011 BRENTWOOD, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Euneral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock to hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 / the attending phoched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Dav Year Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t lirector, page 2 s autopc, performed autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 10 Hospital Other: 1 🗌 Yes ျှ 1 Inpatient 2 I ER/Outpatient eral Director: After this filled in by the funeral di Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

CR 5

State 31. Daté filed (Month, Day, Year)
Registrar APR 1 3 2011

29b. Signature

d title of certifier

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6^{ay}, 201^Y1^{ar} April 1 4:38 A M Thomas Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Cheverly, MD Prince Georges Community Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 2 /47th 93 4ear) Washington, DC Director 579**-**42-5035 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Maryland Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20743 6609 Weston Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. Specify: Black Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" Completed 3 Divorced 4 Divorced Year or Dates id Mental Hygiene. marked other than "natural natic event, the Medical E∂ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service 12 Warehouseman permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last)
John L. Smith 18 Mother's Name (First, Middle, Maiden Surname) Jannie Harrion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6609 Weston Avenue, Capitol Heights, MD 20743 (wife) Barbara Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Washington National 4/13/2011 Suitland, MD Sig 44 of Funeral Service License 22. Name and Address of Facility ope Funeral Homes, P.A. 20747 1 mm ons 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death MINUEL Acutel Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 4 Pregnant at time of death
9 Unknown 5 Other (specify) by the g Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has director, page 2 Obs/rucleus 1 ☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 × No မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral! 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my existing death according to the cause (s) and manner as stated. Medical 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year APR 1 4 2011

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

024720 RAVINDERK. 29d. Date signed (Month, Day, Year) 1081 11

me

29c. License number

Medical Examiner: On the basis of examination almost investigation, in my spiriture of the cause (s) and manner as stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 16 2011 8:10 AM April William Sweeney Joseph /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Months 81 164-24-3628 Director 12/30/1929 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Modeal Exemiter man be notified at 1 ☐ Yes 2 XNo Director Maryland Charles Hughesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20637 USA 15883 Prince Frederick Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) J Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Electrician permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygin Important: If item 27 is marked other i any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cornelius Ralph Sweeney Eleanor Reed 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3599 Silk Tree Ct., Waldorf, MD 20602 Anne Casler/Daughter Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 04/22/2011 4 □ Donation 5 □ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 111 MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Muston Echal. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aneurysin (presumed) **Physician** bdo min disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 ☐ Unknown 9 Unknown ģ signed d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has certificate 1 □ Yes 2 🗷 No Division of Vital Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending Injury 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number SIGNING AS DIRECTOR OF ED 4-18-11 006762 30. Name and address of person who completed cause of death (Item 23a) (Type, P. John, Schnabel 100 HospHall RD Prince Frederickims 20678 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State APR 20

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ Reina Elizabeth Salinas 201 Tea 9:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick 611 Hedgerow Court 5. Social Security Number 8. Date of Birth $J_{an}^{(Month, Day)}$ If Under 1 Year I If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X F Year 961 Efoustry lvador **Director** 50 Yrs 217-08-2629 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 XX Yes 2 No Maryland Frederick Frederick rms 23a or 10e. Street and Number 10g. Citizen of What Country? 21703 United States 611 Hedgerow Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ò þ 1 Never Married 2 Married 2 X No 1 Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 x Yes 2 □ No Specify: Salvadoran Specify: White "natural" Completed 3 Widowed 4 X Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Houskeeping Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josefina Salinas Emilio Salinas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Hedgerow Ct., Frederick, MD 21703 Department of Health ar Important: If item 27 is any injury or other trau Lucy Aguilar / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20c. Location - City or Town, State April 13, 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specific 2011 Frederick, Maryland 21. Signature of Fun Service Lice Resthaten Fufferal Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death O yrs -23a. Part F. Enter the disp ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Cancer of Cervix Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): -transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 X No the Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cancer of Breast 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform Yes 2 No 1 🗆 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 2 X No ျ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗵 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending death. 1 Yes 2 No Director, / ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide after determined e Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Exam 3 Certifying Jur er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F e Practioner To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifie

1 2 2011

31. Date filed (Mor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Julio Menocal, M.D. 110 Baughman's Lane #140, Frederick, MD 21702

32. Registrar's Signature

29c. License number D-31912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month da ea 0855 AM 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 Months Days Hours Min. March Day 3 1949 Maryland 220-46-3620 62 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Maryland Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19515 Frederick Road, #160 20876 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ■ No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: If Yes Give Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 County Government Bus Attendant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Mary Duvall Pickett Charles M. Pickett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette P. McGraw/ Sister 3393 Grade Road, Falling Waters, WV 25419 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Place of Disposition (Cremeter Cremeter) Territorium Inc. 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify 04/12/2011 Alexandria, Virginia 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 21. Signature of Funeral Service 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burlal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death been signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy prior to completion of cause of perform death? 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No 욘 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a To the Funeral D 29a Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 990

DHMH 17 Rev 7/2009

State

Registrar

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strar's Signature

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20 TT 5:25 Рм Geraldine L Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Hours July 13, Year 948 Mary Tand 62 Director 217-46-5455 Usual Residence of Decedent 28a-f shov and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 X No Damascus Maryland| Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20872 11209 Mountain View Road U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ N. Johnson Guy Johnson Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11209 Mountain View Road, Damascus, Maryland 20872 Kris Stiles - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State Metropolitan Crematorium 4/11/11 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Molesworth-Williams P.A., Fu
26401 Ridge Road, Damascus, 21. Signature of Fun ral Service Discosee Funeral Home 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final RENAL Ph_sician/ STAGE DISEASE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? page 2 should be detached for Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **N**o မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check D0061410 APRIL, 09, 2011

Registrar

DHMH 17 Rev 7/2009

State

SIA

31. Date filed (Month, Day, Year)

801 TOLL HOUSE, FREDERICK, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> Physician/ Month April 8 Eileen F. Stull Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10019 Dublin Road Walkersville 8. Date of Birth (Month, Day Sept. 10 5. Social Security Number 1 Year If Under 24 Hrs. **Funeral** Min. 1 □ M 2 🎛 F Months Hours Year 917 Director 93 215-34-3542 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10019 Dublin Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Force ò 1 Never Married 2 Married 1 Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", 3 X Widowed 4 ☐ Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and 2 should be f Health and Menta Aaron Rice Estie Guyton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Paul Stull/ Son 7308 Black Mill Road, Thurmont, Maryland 21788 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1. Department of I Important: If it fo cemetery, crematory or other place) 1 Buriat 2 Cremation 3 Removal from State 4/13/2011 Christ 4 Donation 5 Other (Specify) Faith United Church Frederick, Maryland. 21. Signature of Funeral Service 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ heimer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? signed by the atte 9 Huknown 9 Unknow P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed 2 should 24a. Was an has autopsy perform page To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h Yes 25. Was case referred to medical **Division of Vital** completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2/2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick,

State Registrar 31. Date filed (Mon

DHMH 17 Rev 7/2009

ODIGINAL

32

Registrar's Signature

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dhknown

Day

Vear

Approximate Interval Between Onset and Death

leavs

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 🔀 No

Maryland

Frederick

14. Race - American Indian,

White

Black, White, etc.

2:00p M

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Month

4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month P M Elizabeth 2011 7:30 Staub April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Airy Frederick 8. Date of Birth (Month, Day, Year) Feb. 25, 1922 Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 1 M 2 K Maryland Director 89 Yrs Feb. 214-16-1522 Usual Residence of Decedent of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎇 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7108 B Edgemont Road 21702 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Accountant Hardware Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Norman Thomas Ramsburg Nellie Mary Frances Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25425 permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 356 Morning Calm Lane Harpers Ferry, West Virginia Herbert E. Ramsburg, Sr./Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State April 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 2011 Resthaven Mem Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the diselector complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Tenal Physician/ ail Use Medical resulting in death) Examiner rdiomy o ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir arteri the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed crongry Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 X No al or Attending Physician: The safter death.

It Director: After this certifical of Vital director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, To the Hospital within 24 hours a To the Funeral E Medical 1 Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James L. Roessler, MD 300 5. CHORCH 87. MIDDLETOWN, MD. 21769 31. Date filed (Month) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 11:50 PM DOROTHY JANE SNYDER April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 6. Sex Month, Day Year) une 26,1933 1 □ M 2XXF Days Hours Mary Land 220-28-7707 Yrs Director June Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland Frederick Myersville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21773 Funeral 9138 Myersville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Apartment Complex Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Dorothy Sykes Riddlemoser Howard Martin Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9138 Myersville Road, Myersville, Maryland 21773 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Clinton H. Fleming - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4-12-2011 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Intra cerebra disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No signed by the atte Month Day Pregnant at time of death 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ patient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 De 0 31. Date filed (Mont 32. Rigistrar's Signature

21702

Year

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mor Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F Months a **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a **Funeral** 900 SUNNY BROW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WhITE 3 ₩idowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NTING COM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a MD. 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -Z.5 DENTON 22. Name and Address of Facility AUGHERTY FUNERAL HOME any Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the dise Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequent Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det ģ Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No Yes director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 2 Accider 3 Suicide work?
1 Yes 5 Pending 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) 2260 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 0030 Ам Jacquelyn Steinert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun Ceci1 Calvert Manor Healthcare Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🔀 F Months Days Hours Min $J_{\rm u}^{(Month, Day)}$ Year) 1928 Director Massachusetts 011-22-1813 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1881 Telegraph Road 21911 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 🛱 No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) In Her Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve John G. Barry Theresa Crotty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judi Rodemich/Daughter Silchester Court, Elkton, MD21921 20b. Place of Disposition (Name of 20a, Method of Disposition Arlington National Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Unk Arlington, VA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signa ure of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final multi.m Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Vear Day ☐ Pregnant at time of death☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 ☐ Yes 2 ☐ No Yes 2 F No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Varsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) Derdro DO044373 19 201) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Joseph K. Weidner, Jr., M.D., 101 Colonial Way, Rising Sun, MD

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Glenwood Lee Tilley, 2ั011 рM 1:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center LaPlata Charles 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 😾 M 2 🗆 F (Month, Day, Year) **Director** 579-50-6650 16, 194d Maryland Usual Residence of Decedent items 23a or 28a-f sho her must be notified at 10c. City, Town or Location Director Maryland Charles LaPlata 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5630 Hill Top Road 20646 U.S.A. ก "natural", or item ledical Examiner ก 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Completed Specify: White 3 ★ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Airport 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenwood Lee Tilley, Sr. Olive Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floyd W. Tilley Brother 7500 Simms Landing Rd., Port Tobacco, Md. 20677 20b. Place of Disposition (Name of cemetery, crematory or other place) April 13, 2011 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md 20640 23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ oronary disease or condition Medical resulting in death) Expired Examiner Stage 1 di Scerse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin Due to (or as a consequence of) resulting in death) Last 40 pm Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Day 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ perlipidemia Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 \square Yes ရု After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🔀 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D35295 4/8/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760

P.O.

Records,

Division of Vital

1CB3 State

Registrar

10 St. Partricks SATISH JUMANI 31. Date filed (Month, Day, Year)

APR 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended # 26perMD FCHD KS 4/11/Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Catherine Riggles Toms 20 l°i 8:00a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 220 Glade Blvd. Walkersville Frederick Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 29, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F Months Days Hours Min. Country) Maryland 77 Director Yrs 220-28-7951 1933 June Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Maryland Frederick Walkersville o 10e, Street and Number pe i 10g. Citizen of What Country? Funeral ms 23a must be 220 Glade Blvd. 21793 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Black, White, etc. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: "natural" Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7/ Health and Mental Hygiene. em 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 Dental Assistant Dentist Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lawrence Riggles Catherine Inetta Danner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Richard M. Toms/ Husband 220 Glade Blvd. Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) UNKNOWN 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ interstal Medical Examiner ears Sequentially list conditions, if any, reading to immediate Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ò in the past 12 months? Month Year Day Pregnant at time of death 2 1 NG detached 1 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Rheum atold Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed 2 🗆 No 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certificated filled in by the funeral director, I of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence မ 2 40 1 Inpatient 2 Inc + 3 □ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural injury Division 5 Pending Accident 1 Yes Investigation 2 🗌 No 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hin 24 hours af the Funeral Di npleted filled ir Medical Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 9.Zer 201 D66166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Toll House Suite B2, Frederick, Maryland 21701 Mudusar Raza M.D. 801

DHMH 17 Rev 7/2009

State

Registrar

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend#2pfh4/15/2011ccdohrb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Annie Lillian Thomas April 1 20°°11 4:45 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Future Care Pineview Nursing Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2X F Days 87 Director Yrs 0941 16 22 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Temple Hills MD Prince George' 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 6001 Fisher Road 20748 JSA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Private 9th Domestic Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ပ္ Harry Thomas Mary Countiss permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4508 Weldon Dr. Temple Hills, MD 20748 Theresa Salters/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Resurrection Cem. 4/15/2011 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signaturé of Funeral Service Licens 2294 Old Washington Rd.Waldorf, MD 20601 23a. P 1 1. Enter the diseare, or complications that caused struck, or heart failure, list only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Fin-Physician/ disease or condition resulting in death) ≱ Medical Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on). Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzhemer dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Upknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1100 Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) venue 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death TUCKER APRIL Physician/ ROBERT 2011 2:45P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LA PLATA CHARLES 6685 HORSESHOE DRIVE 8. Date of Birth MAY^{th, Pay} Year 920 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 569-09-0193 **Funeral XX**M 2 □ F Months CATTFORNIA 90 Director Usual Residence of Decedent show or 28a-f shov notified at 10a State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director LA PLATA MD CHARLES 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral U. S. A. 6685 HORSESHOE DRIVE 20646 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Ves 2 No
If Yes, Give 43 - 63 Black, White, etc. þ 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: WHITE Completed XXWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) U. S. AIR FORCE MAJOR Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY TUCKER CHARLES TUCKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $6685\ HORSESHOE\ DR.,\ LA\ PLATA,\ MD\ 20646$ MARILOUISE TUCKER/SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State APRIL 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETS • CEMETERY 27, 2011 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ weeks disease or condition Medical resulting in death) Dementia Examiner Years Sequentially list conditions, Examine Due to (or as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillation, been signe should be Hyperension, atrial 1 Yes 2 No 3 Probably 4 Unknown carutid Stenosis, CVA, peripheral 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Jas page 2 Vascular dispase performe Hospital or Attending Physician: The 1 🗌 Yes 2 🗌 No certificate 25. Was case referred to medical examiner?

1 Yes 2 70 Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{PAssidence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifier R. Sindtevari D-61614 April 215+, 2011 4x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

SINDHWANT, M.D.

APR 28 2011

POST 32. Registrari Signatue

OFFICE RD. WALDORF, MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Gertrude Nancy Mator Travers Apri 2140 Medical 0 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Easton Talbot Memorial Hospita Social Security Number 7. Age (In yrs. last birthday, Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Y 1 □ M 2 🗗 F Min. Dela Ware 221-36-698 Hours Director 2 Usual Residence of Decedent items 23a or 28a-f show 10b. County the Medical Examiner must be notified at 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 No Mbridge 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? USAPage 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 10 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hostes Nancu Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Jard MaJor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code, Julia S Important; If item 27 injury or other 20a. Method of Disposition Fraver 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cambridge, M.D. 4 Donation 5 Other (Specify) CUYTAN Bromwell P.A. 22. Name and Address of Facility, Henry Funeral Signature of Funeral Service Licenses Home, P.A. Henry Washington Sti Cambridge 510 23a. Par 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by oci Zuves 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 2 40 Hospita Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 \square Pending 1 🗌 Yes 2 🔲 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Image: Institute the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Image: Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year eted cause of death (Item 23a) (Type, Print) 509 105 21601 taston MD 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Sea Fill C916 6/08/2011 Per Throng Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Phv11is **Arlene** Woodland 12:27 P.M April 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3910 Regency Parkway; Apt. Prince Georges Suitland Year) 1958 9. Birthplace (State or Foreign Country) cial Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Days Hours 368-90-4023 52 Washington, D.C Director September 19, Usual Residence of Decedent 23a or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland Director Suitland [] 1 X Yes 2 No Maryland | Prince Georges 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 United States 3910 Regency Parkway; Apt. 303 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black. White, etc. <u>Ş</u> 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes. Give Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Prince Georges County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha State Attorney Office Administrative Aide vear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Wenta Important if item 27 is marked any injury or other traumations. 2 White Fairfax Woodland Pear1 E11a Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4804 Fable Street; Capitol Heights, Maryland 20743 Pearl Ella Craven (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Suitland, Maryland 4 Donation 5 Other (Specify) edar Hill Cemetery 2011 Signature of uneral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.:600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Hypertension Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit **Heart Condition** that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Year Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☑ g ☐ Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 Yes 2X No 3 Probably 4 Unknown Completed should 24a. Was an 24b Were autopsy findings available prior to completion of cause of death? certificate has performed 2 No Yes 2 X No 1 Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 X No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D18092 7, 2011 April 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ihn Whaw Roh, M.D.; 5107 Silver Hill Road; Suitland, Maryland 20746 32. Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Year R. Wiggins 2:15 PM 2011 Apri] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Temple Hills <u>4002 19th Avenue</u> 8. Date of Birth (Month, Day, Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 □X= Hours Min **Director** 230-52-6660 68 08/08/1942 Virginia Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Temple Hills Maryland | Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4002 19th Avenue <u> 20748</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 XMarried Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify "natural" Completed 3 Divorced 4 Divorced Specify: Black Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerk McDonalds Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Lee Wiggins Easter Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irnet Wiggins (Sister) 4002 19th Ave. Temple Hills, MD 20748 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ò 1 Durial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Chesapeake Cematory :4/13/2011 Beltsville, MD 21. Signature neral Sovice Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home and 9013 Annapolis Rd. Lanham, MD 20706 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Type II Diabetes, alzheimers Disease 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 **X**No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa**r** ure and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Wilson 4710 Auth Place #595 Temple Hills, MD 20748 Date filed (Month) State

Registrar

APR 1 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 April Physician/ PM Ruby May Nelson Welch 1:30 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis 4 8 1 Anne Arundel Bay Ridge Nursing Center 8. Date of Birth (Month, Day, Yea January 11, If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday **Funeral** Charleston, WV Months Hours 80 **Director** 990-00-0003 January Usual Residence of Decedent show or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a on the Medical Examiner must be Funeral 21403 900 Van Buren Street, #29B USA permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛛 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: African American If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Government Printing Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service Office 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Nelson Rachel Lyles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Perry Becker / Attorney 14300 Gallant Fox Lane, #218, Bowie, MD 20715 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 🗵 Burial 2 🗌 Cremation 3 🗌 Removal from State 4/19/2011 Forestville, Maryland Epiphany Church Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 4739 Baltimore Avenue Þ Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or ach line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 . use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the ar ☐ tes ∠ _ ☐ Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? page 2 has autopsy perform 1 Yes 2 No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Hospital or Attending Physician: Be 26. Place of Death (Check only one) funeral director Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending after death. 1 🗌 Yes 2 🗌 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10063681 12 11

State Registrar Ajit Kurup, 4922 LaSalle Road, Hyattsville, MD 20782

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 1 3 ZULI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20^{Year} Willey Elbert 10:35 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24400 Willey's Way Hollywood St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Days 1 🔀 M 2 🗆 F Months Hours Min 01/24/1922 **Director** 212-28-8076 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Maryland St. Mary' Hollywood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 24400 Willey's Way United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Armed Forces?
1

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Supervisor Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Edward Willey Ethel Bramble Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Willey/Son 23919 Mill Cove Road, California, MD 20619 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/22/2011 Hollywood, Maryland 21. Signature of uneral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield 22955 Hollywood Rd., Leonardtown, MD 20650 Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CAN CEX Dhyllician/ WETASTATIC disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER 2 No 3 Probably 4 Unknown 1 Tyes peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy certificate Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 5 Pending work?
1 Yes 2 No 1 Natural death. Accident Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the □ Accider
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 11/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

RATHAMA S. G'LL SMAN ASSOCIATES

56096

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3744 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia A. Whisner April 6, 2011 2:45 p. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Months Days Hours Min 1 M 2 SZ F **Director** 214-42-1042 76 Maryland Aug Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Motter Avenue 21702 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 white If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify. Completed Year or Dates other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Roland A. Bennett Nellie Smith th and M 19a. Informant's Name/Relationship (Type, Print)
Nancy Abrecht - Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 1557 Crest View Avenue, Hagerstown, Maryland 21740 Page 1 and 2 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Pine Grove Cemetery 4-11-2011 Mt. Airy, Maryland 4 Domation 5 Other (Specify) 21. Signati re of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home anu uce 1621 Opossumtown Pike, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Non-small cell lung cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E. ter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed' Yes 1 🗀 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Hospice House 2 1 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 124 hours after deat e Funeral Director; 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 ___, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 ___, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Miller, CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) APR 1 1 2011 State Registrar's Signature backs

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month wasner -laxa 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Waldorf Center Waldorf Charles 8. Date of Birth
(Month, Day, Year)
1-16-35 9. Birthplace (State or Foreign Country) Maryland Funeral 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Days Hours Min. 1 M 2 X F **Director** Yrs 214-30-0956 76 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1x Yes 2 No Maryland Prince George Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 9524 Croom Rd USA 20772 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 0 Completed by 1 Never Married 2 Married Yes Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", 3 Midowed 4 ☐ Divorced Year or Dates Black any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Aid P.G. Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John T. Warner Edith Smith and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Allen Warner/Son 8909 Fairhaven Ave, Upper Marlboro MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of Department of h 20c. Location - City or Town, State Date cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 4-15-11 Clinton MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death GI TOGIC Physician/ Newslann disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Anaemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) CUA that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by secondacento CUA COPD. D. Records, 1 \square Yes 2 \square No 3 \square Probably 4 \nearrow Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 N 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Manner of Dea 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 071199 04/12/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Josiin Varhoupilly 2007 Tidewates Colony Porive Suite 1A Annayolus 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ April 8, 2011 12:00P Marie Elizabeth Williams Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5005 Bridgeport Drive Suitland Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Aug 16, 1 □ M 2 😿 F Months Days Min. 181-24 - 3869 80 **Director** PA Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5005 Bridgeport Drive 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status er than "natural", or iter the Medical Examiner 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give 2 **XX**No Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72. In and Mental Hygiene. Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Andrews Federal Credit Union permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any Injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Ambrose** Rougeux Cecilia Bergey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Jones (Niece) 10449 Kardwright Court, Montgomery Village, MD 20886 20a. Method of Disposition
1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Maryland Veterans Cemetery 4/12/2011 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 m00357 27. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Bladder Comcer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, It any hading to immediate. Enter Underlying Cause (Disease or iinjury Due to (prasia consequency of) and -transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): the burial physician by Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 W No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? this certificate 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🖵 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗌 Nursing Home 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending work 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) MD DS2289 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2310 Nalin Mathur, M.D. 11855 Holly Lane Suite 107, Waldorf, MD 20601

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A Month 41 AM Ellsworth Wigfield Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign 12 M 2 🗆 (Month, Day Year) Pennsylvania **Director** Sept. 1922 218-16-2911 88 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1128 Sunnyside 21742 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wigfield Edith Sigel Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Wigfield / Spouse 1128 Sunnyside Drive, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4/19/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or compligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Due to (or as a co is quence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. -tran and Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day 2 No signed by the g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of Date of injury 28c. Injury at Natural Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: ,

completed filled in by the t Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 27575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND ampus RD STE 130 HAGERSTOWN LISA HIGGINBOTHAM 11110 Medical 3H-0+1 31. Date filed (Month gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Mary M. Waters 04 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico the L If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day Year) 4 - 9 - 2011 **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 M 2 XF Days Hours Country) Director 216-18-8079 86 MD items 23a or 28a-f show her must be notified at 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 Hammond Street 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian mportant: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 3 XWidowed 4 ☐ Divorced Spedblack Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Poultry Processing aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Smith Maggie Benston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hammond Street, Salisbury, MD 21804 Bruce Waters/Son 20a. Method of Disposition 20c. Location - City or Town, State (Unionville) 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Trinity UMC Cem 4-16-2011 Počomoke, 22. Name and Address of Facility 17 Bennie Smith 21. Signature of Funeral Service Licenses W. Isabella St. Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ NUESI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the aid be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has certificate 2 No 1 Yes Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital 2 D/No 1 🗌 Yes Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director; After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manne f Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **U** Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERN SHORE DR. SAL PR 13 31. Date filed (Mo

State Registrar

M. Waters

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Agnes Blanche Wilson APRIL Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death legimal alisbur WICOMICO If Under 1 Year If Under 24 H/s 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Min 08/13/1923 220-05-1872 Maryland Director 87 Usual Residence of Decedent 28a-f show 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21856 USA 22106 Royal Oak Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Black Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Poultry + Seafood Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Mitchell Leola Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Frenzella Wilson/daughter 22106 Royal Oak, Quantico, MD 21856 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Odd Fellows Cemetery 8/15/2011 Wetipquin, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Liven le Stewart Funeral Home by Holloway and Downey,P.A. 821 West Rd., Salisbury, MD 21801 Hell R 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) m 0 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, il any, leading to in neglate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year P.0. e detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be d 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Npatient 2 ER/Outpatient 3 DOA Certificate: To this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending Division 1 Tyes Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1008. CARROLL ST. SALISBURY Md. 21801 VohRA MD State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4 Dorothy Zimmerman 2011 1:51 Jane ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin, MD Worcester Atlantic General Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Months Days Hours Min. (Month, Day, Year) 2 DeTaware Director 79 221-18-8742 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Delaware Kent Wyoming 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19934 USA 16 Meadow Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: White If Yes Give 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event terms. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Floral Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Durant Clark Elizabeth Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Zimmerman, 16 Meadow Ave., Wyoming, DE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Sharon Hills Mem. Pk4-9-2011 | Dover, Delaware 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityPippin Funeral Home, Inc. 149 W. Camden-Wyo Ave., Wyoming, DE 19934 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Completed by Physician/Medical for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 5 Other (specify) Dav Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ecords, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? page 2 s Hospital or Attending Physician: The 1 Tyes 2 No Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No ၉ 1 Inpatient 2 ER/Outpatient 3 IDCA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Reactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check within 2 To the F only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) 100 Ecamil St. WD 21301 Saloh egistrar's Signatur State 2011 Registrar

DHMH 17 Rev 7/2009

008:31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 13751 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:15A. Frances I. Anderson Medical 2011 <u>April</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto. 4 Perryoak P1. Nottingham Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF (Month, Day, Year) Country, 216-14-7530 86 Hours **Director** July 18, 1924 Marvland Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits notified Md. Balto. Nottingham 1 Yes 2x No 10e. Street and Number 9 10f. Zip Code. ms 23a or must be 10g. Citizen of What Country? by Funeral 21236 USA 4 Perryoak P1. "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black White etc. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes **X**☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 3 XWidowed 4 ☐ Divorced 1 ☐ Yes 2 X No Specify: White Completed ntal Hygiene. ced other than "natura c event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Secretary Blue Cross & Blue Shield Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 7 is marked o မ other traumatic Leroy A. Eney Elsie Strahler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State f Health item 27 James Burke Nephew 4 Perryoak Pl. Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Date 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood 4-27,2011Parkville, Signature of Funeral Service Licensee 22. Name and Address of Facility Address of Facility Schimunek Funeral 9705 Belair Road Nottingham, Md. . Home 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes of each line. Interval Between Immediate Cause (Final Ph sician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to jor as a conse unine of that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 nding p IF FEMALE 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ó Month Pregnant at time of death Day Year ed by the a detached t 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 X No 1 Yes Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dath Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work? death Accident Investigation 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kahnama m.D. 9512 Soite 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 9 2011 Registrar

X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend I per doc g914 4-29-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Marion Andersen 25 25 3.24 AM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 TF Illinois Director 16, 1929 357-22-1960 81 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Examiner must be notified Maryland Harford Bel Air 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 128 West Ring Factory Road 21014 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Benefits Coordinator Public Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmy (unk) Plumbeck ည Harold (unk) Stark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Sandra May / Daughter 401 South Shaffer Dr., New Freedom, PA 17349 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdn 4-27-11 Bel Air, Maryland 21. Signatu/ of Fun Al Service Licent 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complicate shock, or heart failure. List only one complicate shock, or heart failure. c used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DCardia /Medical Due to (or as a consequence of) **Examiner** CENTROCKTON REPROVED BY MEDICAL COUNTY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day 5 Other (specify) 2 🗌 No the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 dnknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an te has page 2 1 ☐ Yes 2 🗌 No 2 - No 1 Yes certificate Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Nnpatient 2 - ER/Outpatient 3 - DOA မ 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 0700PM 1 🗌 Yes 2 No trom Standing 11/2011 death. 2 Accident Director; / 28f. Location (Street and Number or Rural Route Num City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 128 W. Ring Factory Rd home 24 hours a 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) FS-066 30. Name and address of person who empleted cause of death (Nten 23a) (Type, Print) Moatz radle 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend Items 25,27,28a-f per me,g915,05/12/2011dnb

State of Maryland / Department of Health and Mental Hygiene
Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Tems 25,27,28a-f per me,g915,05/12/2011dnb

State of Maryland / Department of Health and Mental Hygiene
Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Certificate of Death Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Margaret Jane Bates 4:38 PM March 25 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 19744 Flat Iron Rd St. Marys Great Mills 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F 230-24-8140 88 Director Oct 14, 1922 Tennessee Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, if a Medical Examiner must be rediffed at Director MD 1 ☐ Yes 2√∑ No St. Mary's Great Mills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 19744 Flat Iron Road 20634 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white ò Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Edward jenkins Zillar Collins ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Durkin/daughter 18210 Stokes Drive St. Inigoes, MD 20684 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or otl once. Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signalure of Furneral Service Licensee Ronald S. Wade de Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Nehe evelororasulas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner مَا مُعَامِعُ مِن المَحْرِينَ وَالْمُعَامِعُ مِنْ المُعْرِينَ مُعْرِينًا مُعْ CERTIFICATION APPROVED BY MEDICAL EXAMINER certificate be execute and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: for use a yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, p 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy certificate performed? 1 □Yes 2 ₩ No Division of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 Certification: 28d. Describe how injury occurred 28b. Place of Injury (Month, Day Year)
12/14/2010 & Unknown | 28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 😾 No Subject fell Could not be 3 ☐ Suicide 28f. Location (Street and Number, or Rural Route Number, City or Town, State) 19744 Flat Iron Road, Great Mills, MD determined 4 Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ND 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Grunda Archana MA 24035 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

Ling Li, MD

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E

April 27, 2011

Please Type or Print in Black Indelible Ink 2 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26 $20^{\circ}1^{\circ}1$ 8:05pm Bril1 Apri1 Rosemarie Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8610 Lucerne Road Randallstown Baltimore 216-28-4562 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 01–11–1932 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Director 79 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Baltimore Randallstown 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8610 Lucerne Road 21133 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2XXNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give "natural", White 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) St. Agnes College (1-4 or 5+) Unit Secretary Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gustaze Fred Browett Mary Catherine Bizzari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8610 Lucerne Rd. Randallstown, MD 21133 Lester Brill (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other placel 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 4-30-2011 Glen Burnie, MD 22. Name and Address of Facility ELINE FUNERAL HOME 21. Signature of Funeral Salvice Licenses J. Wayne Osterling 11824 Reisterstown Rd. Reisterstown, MD 21136 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Nonsma month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has b page 2 sl autopsy perform After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work?
1 Yes 2 No after death

Director: / Investigation 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Dire

completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29c. License number 29d, Date signed (Month, Day, Year) ho completed cause of death (Item 23a) (Type, Print) Name and address of person w BAJIMORE MO 10 Caton U State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Buccheri Month Year 1:40 A M 2011 APri Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 710 Kennington Road Reisterstown 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day,) 1 K M 2 | F Year) 949 Director 61 Yrs. June 212-62-6810 Märyland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Reisterstown 23a or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 710 Kennington Road 21136 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify. Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Warehouse Worker Paper Goods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph S. Buccheri, Sr. Mary Catherine Laurino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Buccheri 710 Kennington Road Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/30/2011 Dulaney Valley Mem. Cockeysville, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Word ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the d. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage Parkinsons disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Completed by Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the aid 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Division of Vital Records, 3 Probably 4 Unknown 1 Tyes page 2 should 24a. Was an 24b. Were autopsy findings available autopsy performed Yes 2 No prior to completion of cause of death? 2 No 1 Yes the Hospital or Attending Physician: 1 hin 24 hours after death. the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 PNo Other: ္ဝ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number ns RyapalneM.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MO 31209 N.S. Rajapakse, M.D. 5-703 2835 5mith AV 31. Date filed (Month, Day, Year) State Registrar

[₩]DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 8:05 APRI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOLLY NANDR TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Yea 5/22/19 Months Days **Director** 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fiem 27 is anaked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 EDGEWOOD U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CollegE JANITOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ (UNKNUWN) 19a. Informant's Name/Relationship (Type, Print)

OAUCHER-IN LAW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) & 12.15 ARMEN D. ALEXANDER ROAD TIMORE MARVIAND EDGEWOOD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 03/2011 CEMETER LAWSDOWNE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE DERRICK C. JONES FIH, D.A. ature of Funeral Service Lic PARK HGTS. AUE. BALTIMORE, MARY/AND 21215 tions that caused 23a. Part 1. Enter the disease, or compli ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ⚠ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 \square Yes 2 🔲 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 2 Registrar	State of Market State of Marke	nylan	64/2 87 2 Cer	of Part of L	Health ai Death	nd Mental Hy	giene	11 13758		
			Decedent's Name (First, Middle, L.)				2. Date of De		3. Time of Death				
	Physicia Medic		Tiffanie	. Cates					MAnth	I Day Z	811 1723M		
mage of the	Examin	er	4a. Facility Name (if not institution, g	ive street and number)	hmore	4c. County of	Death						
	Funeral Director		309.98.0188	Sex 7. Age	23	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bird (Month, Da 6.1.1987	Day Year) Country)			
	and show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Loc	ation				10d. Inside City Limits		
	Maryla 18a-f tified	Director	MD MONTCOME	RY	GAI	THERSBU	RG				1 ☐ Yes 2 💢 No		
	a or 2		10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?		
	h with	Funeral	7908 PEARLBUSH DR.				20879			USA			
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	11. Marital Status 13√3 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Education Armed Forces? 1 Yes 2 XX If Yes, Give Year or Dates.		H	Vas Decedent of Hi Yes, specify Cuba	ın, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		American Indian, White, etc. BLACK		
5-0	"nati "nati	plet	15. Decedent's (Specify only highest	Education grade completed)		(Give I	ent's Usual Occup	ation during most o	of working	16b. Kind of Busi	ness Industry		
121	ithin 7 ene. • than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5-	+)		NOT use retired) ALES	CELLULAR	COMMUNICATIONS				
d 2	z ff g	Be	17. Father's Name (First, Middle, Las				1	18. Mother's	s Name (First, Middle,	Maiden Surname)			
Maryland	should be file and Mental I is marked o aumatic eve	잍	KENNIETH CATES					JANIC	E MARIE REED				
Mar	~ ~ ~ =		19a. Informant's Name/Relationship	(Type, Print)		1			or Rural Route Numbe				
e,	and Heal em		KENNIETH CATES 20a. Method of Disposition		20h Pi		Pearl Bush	Dr., Ap	t201, Gaither	20c. Location - Ci			
nor	1 2 2 2		1 XX Burial 2 ☐ Cremation X 4 ☐ Donation 5 ☐ Other (Spe		CE	emetery, crem	atory or other plac		.18.2011	MUNCIE, IN			
Baltimore,	permit. Page Department Important: I any injury o		21. Signator of Funeral Service Lice	is O	T CRICO								
ä	any Deg		K. GREGORY FINE	14-6	M011	48 F1	NK FUNERAL 6 CRAIN HWY	HOME, P	P.A. t/a MAR EN BURNIE, MD	YLAND MORTU 21061	ARY SUPPORT		
	Inysician Medical Examiner	er	23a. Part 1. Enter the disease or be shock, or heart taller. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a	Conseque	ania ence of):	A	1	rage	/	Approximate Interval Between Onset and Death		
0	ate be executed bhysician and the burial-transit	dical Examine	It any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a				CERTIFIC	AND REPROPERTING	Enm			
	eath certificate : attending phy I for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	of pregnar	;y		23d. Date						
P.O. Box	the deat by the at ached fo	hysic	1 Yes 2 No 9 Unknown			Month	Month Day Year						
ds, P.C	requires that the de been signed by the should be detached		Part II. Other significant conditions Stage	Renal D	it not resu		nderlying cause giv	en in Part I.	23e. Did to	_ /	ute to the cause of death?		
Recor	rsician; The law re s certificate has be lirector, page 2 sho	Completed by							24a. Was a autop perfo	rmed? prid	re autopsy findings available or to completion of cause of oth? Yes 2 No		
ta	ician; certific ector,	Be	25. Was case referred to medical examiner? 1 Yes -2 - No	Hospital:					(Check only one)	801			
<u>\</u>	Physical this craft dir	6	1 Yes -2 to No 27. Manner of Death	1 Inpatie		ER/Outpatien 28b. Time of		4 L Nurs	ing Home 5 Resid		Specify)		
0 0	nding ith. ; After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	injury	28c. Injury work M 1	?		ow injury occurred			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. The Funeurs after death. The Funeurs after death. The Funeurs Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as it	al Certificate:	3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Injur	y - At hor (Specify)	ne, farm, stre		100	Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Me al Exa	nysician: To the best of miner: On the basis of exa	amination	and/or investi	gation, in my opinio	n, death occu	irred at the time, date a	nd place, and due to	the cause(s) and manner stated.		
	70 th		29b. Signature and title of certifier		· · · · · · · · ·		29c. License			29d. Date signed (A			
			P YOU CF	1NY			1710	11538	320 .	April	3, 2011		
			30. Name and address of person who 22 S. Green	St. Bat	tin	voce,	MD ²	JUIVE	im Bower	Warylar	d Medical Conte		
	Stat Registra	_	31. Date filed (Month, Day, Year)	32 Registrar	's Signatu	lire Ann	Kel		1	3			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per inf g916 6-20-11 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Herbert Paul Cutright 04 26 2011 1610pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center
5. Social Security Number
6. Sex
7. Age (
233
223
30-5914 Baltimore Roseda | P If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 91 Yrs. Director Nov. 20, 1919 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2√√No Directo Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö "natural", or items 23a 8501 Dempster Court United States Funeral Apt. E 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify: Ş Q Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Customer Service Manager Rotlatch Industries 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daris Cutricht ဥ Rebecca Dooley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau once. 17437 Wesley Chapel Road Monkhon, Maryland 21111 Marlene Riogio (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 29, 2011 Cardens of Faith Cemetery Rosecale, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Cremation

8800 Harford Road Parkville, Man

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear validire. List only one cause on each line. Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760, burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Disease Coronary Artery 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ∐Yes 2 No 1 □Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. neral Director: Aff filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DRSAMMAX RELIDENT 1261 RES 00000 IXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Devadatta Sarmate MD, 9000 Franklin Square Drive, Baltimore MD, 21237 31. Applied 219th Day Year) Linear 32. Reading's Steaming. State Registrar

utright, Herbert

within 24

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

Jonnifer Hayashi

5505 Hopkins Bayview Circle 31. Date filed (Month; Day, Year) 32. Pegistrar's Signature 29

30. Name any address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

D62032

29d. Date signed (Month, Day, Year)

Balto., MD 21224

2011

APRIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL MARIAN M. COLLINS **2**011 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE NURSING CENTER TOWSON BALTIMORE Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours JUNE 30 1924 578-22-3429 Director 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD BALTIMORE TOWSON 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 WEST RD 21204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. WHITE 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TELEPHONE OPERATOR BELL TELEPHONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FRANK J. MORRIS AMELIA UNKNOWN 9a. Informant's Name/Relationship (Type, Print)
DONNA MURPHY-DAUGHTER 19b. Mailing Address (Street and Number or Rural Boute Number, City or Jown, State, Zip. Code) 2241 W. GENESEE RD BALDWINSVILLE, NY 13027 20a. Method of Disposition
1

Marial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 5/2/11 QUANTICO NATIONAL CEM TRIANGLE, VA 22. Name and Address of Facility MILLER-DIPPEL FUNERAL ROME, INC of Funeral Servi 6415 BELAIR RD BALTIMORE, MD 21206 . Enter the disease 23a. Part 1. Enfe sheck, or h e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ andio varue disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has to funeral director, page 2 s autopsy yes 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No eted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year Va. 031861 Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day,

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	1	8	5	8	1	1	Sec.	ě

Samantha Lynn Cra	1- For State Registrar	Certificate of De		Reg. N	lo	13/02
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) SAMANTHA LYNN CRAWFORD			Date of Death Month Date April 25, 2011		3. Time of Death 0851 hrs
Miculcal Examiner	4a. Facility Name (if not institution, give street and number)	4b. C	ity, Town, or Location of Death		4c. County of Death	
· · · · · · · · · · · · · · · · · · ·	10 Ward Avenue		estminster Under 1 Year If Under 24Hrs		Carroll	
Funeral Director	5. Social Security Number 6. Sex 7. Age 213-21-6435 1 M 2 X F	8. Date of Birth (M	M/DD/YYYY) 9. Birth Foreign Coul			
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d, Inside City Limits
≥	MD BALTIMORE	PARKVILLE				1 Yes 2 No
the Maryland a or 28a-f sh tified at onc Director	10e. Street and Number	10f	. Zip Code	10g. C	Citizen of What Count	ry?
th the 23a or notific	8673 OAK ROAD	Entrie H. D. Francisco	21234 cedent of Hispanic Origin? (Sp	anife Van as Na	USA 14. Race - Americ	an Indian Black
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced of Dates:	∭ No If Yes, s	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		White, etc. Specify: WHITI	
5-0036 of within 72 hours aft fygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade com	during most o	sual Occupation (Give kind of vity working life. DO NOT use reti		o. Kind of Business/In	dustry
36 in 72 h in au "1 lical H	Elementary/Secondary (0-12) College (1-4 or 5	+) SERV	TCF		BURGER KI	NO.
d with d with the wit	17. Father's Name (First, Middle, Last)	SERV		(First, Middle, Maid		VG
215 be file ontal H riked cent, til	BERNARD F. CRAWFORD		DEBRA L			
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medical TO Be Comple	19a. Informant's Name/Relationship (Type, Print) DEBRA CRAWFORD/MOTHER		ress (Street and Number or I			Zip Code)
and 2 lealth if	20a. Method of Disposition	20b. Place of Disposition crematory or other p	(Name of cemetery,		c. Location - City or T	own, State
nore ages 1 art of H at: If i other	1 Burial 2 X Cremation 3 Removal from Sta	CATONSVILLE	E. MD			
Baltimore, permit. Pages I an Department of He Important: If ite	4 Donation 5 Other Specify: 21. Sign ure of Funeral Service Vicensee		TORY, INC. 5/			
	HARAGE TRUE WALL	0)21	LOCH RAVEN BL			1286 Approximate Interval
Physician /Medical	a. Part I. Enter the dise se, or complications that caused failure. List only one cause on each line.		ode of dying, such as cardiac o	r respiratory arrest, s	snock, or neart	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Cardiac A Due to (or as a conse					
	Sequentially list conditions,	tricular dila	tion			
nine	if any, leading to immediate Due to (or as a consecute. Enter Underlying Cause Consecutive Cause Cau	quence of):				
ted Insit	events resulting in death) Last Due to (or as a conse	quence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex	d. MUNPENDED AMENDED 23a	-b,pt.II,27,pe	er me,g917 7-14	-11 sm		
60, ate be hysicia e buria	IF FEMALE: 23c. If yes, outcom				23d. Date of delivery	
Sox 6876 Jeath certificate e attending phy Ifor use as the I	23b. Was decedent pregnant in the past 12 months?	Month Da	ay Year			
). Box 687(the death certifica ty the attending pl ched for use as the Physician/A	1 Yes 2 No 9 V Unknown 9 Unknown	time of death 5 Other	Specify)			
Division of Vital Records, P.O. B To the Hospiral or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached ledical Certification: To Be Completed by Phy	Part II. Other significant conditions contributing to death	but not resulting in the under	lying cause given in Part I.		co use contribute to the	
S, P.(uires that a signed ld be dett	Sleep apnea,obesity			1 Yes 2		bpsy findings available
Records, The law requirer ficate has been sig , page 2 should be Completed				autopsy performed	prior to co	mpletion of cause of
Rec ificate r, page	25. Was case referred to medical		26.Place of Death (Check	1 Yes 2	No 1 ✓ Yes	2 No
/ital	examiner? 1 Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatient 3			idence 6 🗸 Other:	Scene
of Vinag Physical Colored Colo	27. Manner of Death 28a. Date of Inju	ry 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
sion titendi death. ctor: y the f	1 X Natural 5 Pending 2 Accident Investigation		1 Yes 2 No	005 1	t and Mumber or Pur	al Boute Number City
Division of spital or Attending tours after death. neral Director: Aft filled in by the function: Certification:	Suicide Could not be determined (Specify)	ury - At home, farm, street, fac	ctory, office building, etc.	or Town, State		al Route Number, City
Hospit 4 hour Funera ely fill	29a. Certifier 1 Certifying Physician: To the best of my	/ knowledge, death occurred a	it the time, date and place, and	due to the cause(s)	and manner as state	d
To the Ho within 24 To the Fu completed	one) 2 Wedical Examiner: On the basis of examiner and manner stated.	nination and/or investigation, i				
کّ اُ اُ	29b. Signature and title of certifier		29c. License number O.C.M.E.		d. Date signed <i>(Mon.</i> pril 26, 2011	th, Day, Year)
	30. Name and address of person who completed cause of di	eath (Item 22a)	O.O.IVI.L.	^	p.ii 20, 20 i i	
	Donna M. Vincenti, MD Assistant Medic		Baltimore Street, Baltir	nore, MD 21223	3	
State	4	's Signature				
Registrar	APR 2 9 2011	1. parl				
DHMH 17 Rev 1/2001 OCMF 2006	OCAAC	ORIGINAL				

Please Txpe or Print in Black Indelible ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:13 Physician/ James Edward Cronin 2011 Year April 26, Medical 4a. Facility Name (if not institution, give street and number)
3330 N. Leisure World Blvd #126 Examiner 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 5. Social Security Numbe 057–32–0795 8. Date of Birth 9. Birthplace (State or Foreign Country) NY 1**X** M 2 □ F 8/20/1941 **Director** Usual Residence of Decedent 28a-f show 10a. State with the Maryland the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Tes 2 No 10e. Street and Numbersure 3 × 30 N. Leustre World Blvd #126 ò 10g. Citizen of What Country? Funeral 20906 items 23a 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) University 5+Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jeremiah Cronin Dorothy Marie Slater l and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie M. Cronin, daughter 435 E. 77th Street 1B NY, NY 10075 permit. Page 1 and 2 and 2 and 2 and 2 and 2 and Important: If item 27 any injury or other transcrees. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Uniformed Serv. Unv. 4/27/2011 Bethesda, MD 22. Name and Address of Facility Kapp Funeral & Cremation SVCS. Signal fe M01539 933 Gist Ave. Silver Spring, MD, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Colon Cancer Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or it that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year signed by the a id be detached for 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No Yes 21 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of 29c. License number 29d. Date signed (Month, Day, Year) D35635 4/27/2011 WE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Joseph Kaplan MD 18111 Prince Philip Dr. Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Ragistrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ April Chetelat Evelyn Marie 25 7:30 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Prince Frederick Veteran Home <u>Charolette Hall</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, November 9. Birthplace (State or Foreign **Funeral** Country) West 1 □ M 2 🗓 F Months Days Hours Director 235-30-2430 85 Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Dundalk Maryland 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3006 Liberty Parkway 21222 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 XNo __ Yes Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 XNo Specify: 3 Divorced 4 Divorced Year or Dates other than "naturent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Teacher 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Hamrick Irwin Unknown permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3006 Liberty Parkway, Dundalk,MD. 21222 Geoege Chetelat Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilate 30, Important: If it any injury or o 1 Burial 2 Kremation 3 Removal from State Dundalk, Maryland 4 Donation 5 Other (Specify) Oak Lawn Cemetery 2011 . Signature of Funeral Service Licen , e 22. Name and Address of Facility Connelly Funeral Home Of 7110 Sollers Point Road, 23a. Part 1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final ALZHEIMER'S Onset and Death DISEASE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESSENTIAL HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be (26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tyes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) acc MD D0067788 26 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAO IEENA KODALI 29449 Charlotte Hall Road, Charlotte Hall MD. 20622 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar PR

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4c per doc 8914 4-29-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. Certificate of Death Decedent's Name (First, Middle. 2. Date of Death 3. Time of Death rouse April Physician/ dol 5:15 p M 2011 Medical a. Facility Name (if not institution give street and number. Examiner Town, or Location of Death 4c. County of Death University of Maryland Baltimore Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day April 2 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 MF Min Mary Land 931 Director Usual Residence of Decedent 28a-f shov 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Aberdeen 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Apt. 122 USA 700 W. Bel Air Ave. 21001 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: and Mental Hygiene. Completed Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ည Myrtle Edna Keller Vonley Dewell Gentry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
518 Counterpoint Circle, Havre de Grace, MD 21078 Richard Allen Crouse / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baker's Cemetery 20c. Location - City or Town, State Date 1 😿 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4-28-11 Aberdeen, Maryland McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Stroke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hyperlipidemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as or Attending Physician: The law requires that the death certificate be executed the burial-trans Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) 4 Pregnant g Unknown Month Day Year Pregnant at time of death to the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by per tension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director; 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) C Miller M.D. 1568680980 April 232011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer C Miller MD 22 South Greene St Balkmore MD Miller 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ April 23^{pay} 20 Year 2:25 P M Jeanette Coppa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Days Min. Hours Year) 579-48-1545 1933 Washington, D.C. Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral . Page 1 and 2 should be filed within 72 hours after death with 1106 Maple Avenue 20851 United States items Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc , or þ 2 🛭 No 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 X Widowed 4 Divorced White Completed Year or Dates er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. County Schools Administrative other 27 is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry L. Burnett, Sr. Bertha L. Glass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 John Coppa / Son 17 Roberge Drive Amherst, New Hampshire 03031 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. May Mary Land Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville, Maryland uneral Service L 21. Signature 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc 300 W. Montgomery Avenue Rockville, Maryland 20850 M01607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Fulmonary Embolism Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month Dav Year 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Left Total Knee Replacement 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 X Yes 2 ☐ No မ 1 Inpatient 2 X ER/Outpatient 3 IDOA • Hospital or Attending Phys 24 hours after death. • Funeral Director: After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 2 Accident
3 Suic M 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the Masterson ms 1 homas D50534 4/23/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GV Thomas Masterson, M.D. 6858 Old Dominion Drive #104, McLean, Virginia 22101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:00 PM 2011 Harold Maurice Carter Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death n/a Union Memorial Hospital Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign MDSountry) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. 0692471943 Director 219-38-5530 67 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2781 Tivoly Avenue 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1^{Elementary/Seconday (0-12)} College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Noah Carter Doris Valena Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Henson-Hawkins-Mother 2781 Tivoly Avenue Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05.02.2011 Baltimore, MD John L. Williams Funeral Directors, P.A. 4517 Park Hgts Ave Baltimore, MD 21215 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ meumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) Month Day a Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law autopsy perform Yes 2 X 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 횬 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Secrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number

AT 2 4 3 8 9 4 6 B11 29d. Date signed (Month, Day, Year) 4/25/2011

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

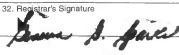
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Emily Ryan 201 University Parkway Buttimuse, Mb 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CLEMONS Year 2011 AMNIE 09 55AM APRIL /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** andallstown center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 □ M **2√**□ F 218-12-3013 90 **Director** 5-25-1920 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show r than "natural", or items 23a or 28a-f shor If a Medical Examiner must be notified at Director 1 ☐Yes 2 No Randallstown Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211.33 USA 5412 Old Court Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ Specify: African-American 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACME Seanstress s 1 and 2 should be filed w if Health and Mental Hygier item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Eason William Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4730 Vancouver Road, Baltimore, MD 21229 permit. Pages 1 and 2;
Department of Health an
Important: If item 27 is
any injury or other trau Alice Outchenber/ Niece 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 5-2-2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest line. 23a. P /t1/ Enter the disease, or complications that causes of k, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ GASTROLINTESTIMAL BLEEDING 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed EMPSTAGE ROWAL DISEMSE 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? CEREBROVASCUAN DISGASE 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 054288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST HUSPITAL CENTER

State Registrar

31. Date filed (Month, Day, Year)

KAMASWAMY I RANG ARADAN.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A PZIL Day. Physician 1100 CONDRY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** tuspital BALTIMORE ANDA LLS TOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours **Director** 034-40-7268 81 30,1929 Massachusetts Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 10d. Inside City Limits MD Howard Director Marriottsville 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 A Marriottsville Road by Funeral 21104 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Health and Mental Hygien.
Important: If item 27 is marked other tha
any injury or other traumatic event, I'm.
ginee. Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ James F. Condry, Sr. Anna G. Zilch 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Frances McCabe-Pers.Rep 1525 Marriottsville Road; Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery 4/26/2011 | Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign Je Funeral Sanice Line ise 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARDIOPULMONARY /Medical Due to (or as a consequence of): Examiner Sequentiany liet our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes signed by the a 9 Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MOJENSTOFF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has tirector, page 2 s autopsy performet 2 Yes 2 No 2.X No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 □Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my coloring death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29c, License number D42723 29b. Signature and hip of certifier 29d. Date signed (Month, Day, Year) Holl ONY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVVERIAL LARISH. HOSPIZAL BURTROAD NORTHWEST lev mp 21133. OLD 540 COUTET

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month 3. Time of Death 2011 Physician/ 05:27 PM Yvonne Lynette Johnson Carter 20 Medical WW 1 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F Days Hours Min. 06/23/ **Director** 219-76-4353 1960 50 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2839 Parkwood Ave. 21217 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CNA Private Duty 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Edward Johnson Helen Talley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Allen Carter(husband) 2839 Parkwood Ave., Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) on-site Crematory 04/26/11 Baltimore, MD 21. Signature of Funeral Service Licenses ²Josephorf Brown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD 21217 umo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Cance year. Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **To the Funeral Director:** After this certificate has been signe completed filled in by the funeral director, page 2 should be a Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 🗌 Yes __ Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{\text{Nursing Home}}\) 1 \(\text{Residence}\) 6 \(\text{\text{Other}}\) Other (Specify) \(\text{Specify}\) 1 \(\text{h}\) 1 \(\text{h}\) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending Accident 1 Yes 2 | No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of pe

31. Date filed (Month, Day,

Aughby Blud 21061

on who completed cause of death (Item 23a) (Type, Print)

2

bach

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Manyland 4728720 Philip Health and Mental Hygiene For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 13, George Frank Delost 201^{Year}_{1} 7:05 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Health & Rehab. Glen Burnie Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/08/1922 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign **Funeral** Days 1 🗆 XM 2 🗆 F Months _{Country)} Marvland 216 12 9325 Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fen 27 is marked other than "natural" or its any injury or other trainmants. 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/A Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1601 Ceddox Street 21226 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates. WW I] 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced WW II White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MD Drydock Chipper / Caulker 4 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Delost Anna Helen Zuelke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Delost / son 213 Pennsylvania Avenue Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 03/17/2011 Baltimore, Maryland Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani MENITI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Terminal 1 Yes 2 No 3 Probably 4 Wiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe nis certificate h I director, page 2 🗆 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 X Yes ျပ Other 1 Inpatient 2 ER/Outpatient 3 DOA this rsing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? n 24 hours after death.

e Funeral Director: Af oleted filled in by the fu 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Fxaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted f within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi-

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed caus

APR 28

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 29d State of Maryland, 02923772611 and Mental Hygiene, State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 45 AM enora Garn 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL CENTER Baltimore Rosedale Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Hours Min 6-38-9379 **Director** Usual Residence of Decedent or 28a-f shov 10a, State 10b. County Director 10c. City, Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits timore 1 es 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces ı ∟ Yes If Yes, Give Year Black, White, etc. ō Completed by 1 Never Married 2 Married 72 hours after 21215-0036 1 Yes 2 No Specify. "natural". 3 Widowed 4 □ Divorced Year or Dates. any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working marked other than Seconday (0-12) life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) HCIA Be Maryland irst, Middle, Last Mother's Name (First, Middle, Maidel ၉ nett Town, State, Zip Code) 110 AND 21093 19b. Mailing Address (Street and Number or Rural Route Number, City or Da Baltimore, Location - City of Town, State 20a. Method of Disposition Burial 2 🗌 Cremation 3 🔲 Removal from State Donation 5 D Other (Specify) lorth 21. Signatur Funeral S ce Lice see resal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) Musicardial

Due to (or as a consequence of): cardial infarction Medical **Examiner** 136000 SSIVE Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed TOWARD ROVED BY WEDICAL EXAMINER For ovaria ery attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown the detached 9 I Linknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has funeral director, page 2 autopsy performed' 2 🗌 No 2 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examinar? Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury ☐ Natural 5 Pending death. surgery 4-20-2011 Accident Investigation 1300 PM 2 - No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 9000 FRANKLIN SQUERE (O.R.) ISCUTO MC ZIZ37 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined 21237 9000 FRANKLIN Square Hospital 24 hours DR BALTO and Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) the within 7 29b. Signature and title of certifier ٥ 29c. License number 29d. Date signed (Month, Day, Year) April 21, 2011 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) charles R. Boic FRANKLIN Sauase DR. Balto md 21237 2 9000

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Registrar's Signat

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gerald Harrington Daniel, Sr. . 20<u>11</u> April 27 1:40 a.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3340 Level Road Churchville Harford County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Months 428-42-6158 84 New York Director 1927 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Harford County Maryland Churchville 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3340 Level Road 21028 United States and 2 should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, and Mental Hygiene. is marked other than "natural", or iter aumatic event, the Medical Examiner Armed Forces? by Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕍No Specify: If Yes Give Specify: White 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 Elementary/Seconday (0-12) AT&T Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Edwin Calaway Daniel Alice Deisel of Health and Menta item 27 is marked other traumatic e 19a. Informant's Name/Relationship (Type, Print)
Mrs. Elizabeth Daniel (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3340 Level Road, Churchville, Maryland 21028 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Evans Funeral Chapel 1 Durial 2 Toremation 3 Removal from State Forest Hill, Maryland 04/29/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Evans Funeral Chapel & Cremation Services-BelAir 3 Newport Drive, Forest Hill, Maryland 21050 Jean of Lesm 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
STEARS Immediate Cause (Final Physician/ PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death
Unknown Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Tes 2 No 2 V N Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury I hours after death. uneral Director: Afted filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Manson D0070043 2011 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X Dr. Robin Manson, 6701 N. Charles Street Suite 4105, Baltimore, Maryland 21204 31. Date filed (Month, Day, Year) 32. Registraris Signature State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. T = For State Registrar State of Maryland / Department of Health and Mental Hygien Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1014 M al 201 Medical Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10 Son Year If Under 24 Hrs. Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (\$tate or Foreign **Funeral** 8. Date of Birth Days Months 1 M 2 KF 215-70-312 (Month, Day, Y Country) Director -20-1 Usual Residence of Decedent show 10a. State 10b. Count at 10c. City, Town or Location 16d. Inside City Limits Director notified 28a-f 1 🗌 Yes 2 🗌 No Ora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral u.s. 21212 items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🐪No Specify: "natural", 3 Widowed 4 Divorced Completed Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12. traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant; if item 27 is many Injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ an 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu >0~ Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place! Denation 5 Other (Specify) 4-201/ of Funeral Service Licensee 22. Name and Address of Fac 701 120 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day the detached Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate performed? 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tes Other: မ After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 🗥 O S 🗘 C 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending (Month, Day, Year) work?
1 Yes within 24 hours after death.

To the Funeral Director; At completed filled in by the fu 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ariks M 31. Date filed (Month, Day, Weàr) Registrar

DHMH 17 Rev 7/2009

3. Time of Death Year 7 25 PM 4c. County of Death Ballimore 9. Birthplace (State or Foreign Maryland 1954 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian Black. White, etc. White 16b. Kind of Business Industry Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21015 20c. Location - City or Town, State Beltsville, Maryland 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) -27-2011 oudhury 9000 FRANKLIN SQUARE DR Ballo md 21237 DRadnan Z 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ethel Jane Dagitz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death TONSIA timore Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days 96 Hours Min. Month, Day, Ye Maryland Director 215-03-1336 1914 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director or 28a-f Baltimore 1 Tes 2 No Catonsville 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other them any injury or other traumer-21228 United States 709 Maiden Choice Lane RGT 1125 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dietitian Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Frank Fowler Marv Grover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dagitz /Son 494 Beall Ave Luray, VA 22835 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apr 1 Burial 2 Cremation 3 Removal from State 29 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 Signature of Funeral Service Licensee 22. NaCrematcher Family Funeral Alternatives 10,585 Kelbo 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) rear Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): ilvision of Vital Records, P.O. Box 68760 of or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months 1 Yes 2 No Pregnant at time of death Month Day Year ed by the a 9 Unknown 9 Unknown signed by d be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed Yes 2 No 2 🗆 No 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 No ျှ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation Could not be in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and tille erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Regi

11-03064 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jennifer Lynn Devine 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Reg. No. 2. Date of Death 3. Time of Death Physician/ 0843 hrs **Medical Examiner** April 22, 2011 Jennifer Lynn Devine 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford 404 Regina Road Edgewood 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Months Day Hours Director Jan. 3, 1984 country) Maryland 218-08-9682 27 1 M 2 XF Usual Residence of Decedent IOc. City, Town or Location 10d, Inside City Limits 1 Yes 2 X No 28a-f shov Maryland Harford Street Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1528 Galaxy Drive 21154 USA mit. Pages I and 2 should be filed within 72 hours after death with arment of Health and Mental Hygiene.

vrant: If item 27 is marked other than ""...
or other traumaric event. 16-Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 X No 1 Yes 2 X No specify. White 4 Divorced If Yes, Give Year Specify: Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 Disabled 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Karl Randall Devine Sharon Ann Bare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1528 Galaxy Drive, Street, Maryland, 21154 Heather DeHaven / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Itimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/2/2011 Hilltop Service Corp. Towson, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign re of Fuheral Service License 50 W. Broadway, Bel Air, Maryland 21014 Approximate Interval 23a. Part I. Enter the disease, or compl Thoused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Immediate Cause (Final disease a Methadone Intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED \square AMENDED 23a,27,28a-f,per me,g916 6-7-11 sm ed by the attending physician detached for use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed by ector, page 2 should be detach ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes 2 No After 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Pending 1 Yes 2 X No death. Director: fd 4-22-11 fd 8:35 am Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after Suicide 6 X Could not be or Town, State) 404 Regina Rd. Edgewood, Md. determined found in dwelling Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 23, 2011 O.C.M.E. Marie

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD

State Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

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32. Registrar's Signatur

STONEL AVENUE

L'ESTMUNSTER MANGUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CALLIN

THOMAS

29 2011

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Helen Marie Erickson April Physician/ $201^{Y_{ear}}$ 22 4:45 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cnevy Chase Montgomery 2 Alden Lane If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 351-20-6576 **Funeral** Days Min 1 M 2 XF Months Hours 2 /25th Pay 23 Director Usual Residence of Decedent 28a-f shov 10b. County 10a State IOc. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director Chevy Chase MD Montgomery 1 Yes 2 K No 10e. Street and Number 2 Alden Lane 5 10g. Citizen of What Country? 20815 Code 23a Funeral USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government permit. Page 1 and 2 should be filed within 7. Department of Health and Mential Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Travel Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Feller Walter L. Leppla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Erickson, son 207 Troon Cr. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/26/2011 Beltsville, MD 4 Donation 5 Other (Specify) al Service Licenses 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. M01539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure, List only one cause on each line Immediate Cause (Final Physician/ CHF disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examin that initiated events resulting in death) Last Due to (or as a consequence of) physician are the burial-t Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Day Pregnant at time of death 1 Yes 2 2 9 Unknown signed by the a d be detached f 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 25XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 🔀 No 1 Tes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? injury 5 Pending death. 1 Yes 2 No neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined thin 24 hours a the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/26/2011 M054241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diedre Woods MD 5200 Wisconsin Ave. Chevy Chase, MD 20815 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, 2011 April Physician/ Michael Wilson Fernsler 10:00 A^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 0771771940 Pennsylvania **Director** 214-38-4576 70 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1700 Old Eastern Avenue 21221 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1962 Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: 1965 3 Widowed 4 Divorced Specify: White Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+)
5+ Elementary/Seconday (0-12) Federal Government Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilson Miller Fernsler Helen Catherine O'Neill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lambert (Sister) 620 Quail Street, Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gard: 05/02/2011 Baltimore, Maryland 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Signature of Funeral Septice Licenses . Print the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Imme te Cause (Final dis se or condition Onset and Death Physician/ SEPSIS Medical r ulting in death) **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Stage Chronic Obstructive Airways dirense Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Respiratory Failure 24a. Was an autopsy performed: Atheroscieno AL Cardiovascular divase 2 1 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗆 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 W Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) swong. D 50653 . C 27-2011

State Registrar DHMH 17 Rev 7/2009 31. Date file

GYAN C.

Road Reale M.D

SUIZAN A

20751

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Reale

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, Day 2011 Year Physician/ April WESLEY **FULCHER** 9:00A JAMES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3Fernsell Ct #2B Baltimore 8. Date of Birth 02/01/19469. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**XM 2 □ F Days Hours 04426920911 Marviand 216-44-0289 65 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo Maryland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 3 Fernsell Court #2B 21237 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify: Completed 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **5+** the Vice President Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injuy or other traumatic eve ones. မ Vernon Marvin Fulcher Alverta Helen Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 704 Murdock Road Baltimore, Maryland 21212 Jaime Lyn Tipton 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State ☐ Burlal 2 XX remation 3 ☐ Removal from State GreenMount Crematory 05/04/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FaMitchell-Wiedefeld Funeral Home Inc ignature of Funeral <u>Se</u>r 6500 York Road Baltimore, Maryland 21212 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complication shock, or heart failure. List only one gate Immediate Cause (Final Probable acute mesocardial refarition Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No ed by the a detached i 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should sometial hypertense 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\mathbf{T} \) Residence 6 \(\triangle \) Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) D0026575 04/27/201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARTIG, MD 10155 YORK RD COCKEYSVILLE, MD 21030 10 V STE 200 L alvad 32. Pegistrar's Signature 31. Date filed (Month State

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

3altimore, Maryland 21215-0036

Box 68760

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 25 per me, g914,	184 Pepa Ceri	timent of H	lealth and N Death	/lental Hy	giene Reg. No. 2 (April 1 Day	13782		
	Physicia		1. Decedent's Name (First, Middle, Last) CHROLY N ELIZABETH GREEN		2. Date of Dea		O	3. Time of Death				
	Medic Examin		4a. Facility Name (if not institution, give street and number) SHAPY GROVE ASVENTIST HOSTVL		4b. City, Town, or		1	4c. Coun	4c. County of Death MONTGOMICKY			
	Funeral Director	8	5. Social Security Number 212−68−5712 6. Sex 1 □ M 2 🛛 F 7. Age (In yrs. In Security Number 1 □ M 2 🖾 F 53	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da May 10	th 9. Birthplace (State or Foreign Country) Missouri				
	aryland a-f show fied at	Director		ty, Town or Loca	ation					10d. Inside City Limits 1 ☐ Yes 2 🗶 No		
	the Ma or 283	Dire	Maryland Montgomery Poto	omac	10f. Zip Code			10g. Citizen o	f What Cou			
	h with	Funeral	8549 Bells Ridge Terrace		20854			United				
920	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	lf	/as Decedent of His Yes, specify Cubar ☐ Yes 2 X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White, fy: Wh:			
215-0	רסטן 72 הסטן 72 הסטן Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give ki	ent's Usual Occupa ind of work done d NOT use retired)	ation uring most of work	ing	16b. Kind of	Business In	dustry		
212	ygiene ygiene her tha rt, the		4	Certifi	ed Public	Accountant		Private		ice		
/land	ould be filed nd Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last) Barclay Adams Greene			18. Mother's Nam	e (First, Middle, Adams H:		me)			
Man	sh 7 is rrat		19a. Informant's Name/Relationship (Type, Print) Lilla H. Nash / Mother	1	g Address (Street a p ress Ru r		on, Sou			^{Code)} 29909		
Baltimore, Maryland 21215-0036	age 1 and ent of Hea nt: If item y or othe		1 🔲 Burial 2 🔀 Cremation 3 🔲 Removal from State		atory or other place		1 ^{ate} 25,	20c. Location	-			
Baltir	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once,		4 Donation 5 Other (Specify) Montgomery Crematorium Inc. 2011 Bethesda, Maryland 21. Signature of Funeral Service Licensee M01596 Montgomery Crematorium Inc. 2011 Bethesda, Maryland 22. Name and Address of Facility bert A. Pumphrey Funeral Home / Rockville, Inc. Bookville, Maryland 20850									
	Ph_sician/	0 7	iry zenki	Approximate Interval Between Onset and Death								
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. RESPIRITOR Due to (or as a consequence) CHRONIC OBS	uence of):	ALLMONA	HEY DISHAH	X= (mP)			DEADA		
	o it	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		7 001101			- /.	7	<u> </u>		
	ate be executed physician and the burial-transit	al Examine	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of the consequence).	uence of):		Tron	Y MEDICAL EXA	MINER				
760	cate be physic s the b	edical	d			CERTIFICATI						
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta	у			Date of deliv	very Day Year				
Division of Vital Records, P.O.	uires that the n signed by uld be detac		Part II. Other significant conditions contributing to death but not res			the cause of death?						
Record	The law req	Completed by		o. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available completion of cause of 2 \Box No							
ita	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 XV Yes Hospital: 1 XV Inpution: 2		Otho	ace of Death (Chec						
on of V	nding Physath. ath. TAfter this e funeral di	icate: To	1 X Yes 2 X No 1 X Inpatient 2 □ 27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident Investigation	28b. Time of injury	28c. Injury	4 □ Nursing He	ome 5 🗔 Residente 128d. Describe 1			y)		
Jivisio	al or Atte s after des I Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify		et, factory, office			n (Street and Number or Rural Route Number, Fown, State)				
1	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier (Check check only one) 1	on and/or investig	gation, in my opinio	n, death occurred a	t the time, date a	ind place, and o	due to the ca	ause(s) and manner stated.		
	To the within comp		29b. Signature and title of certifier		29c. License	252		29d. Date sign	19.20	Day, Year)		
(ن			30. Name and address of person who completed cause of death (tem STEVEN 'T, KHEIYA, MD, 10605 ONC	n 23a) (Type, Pr 2014) 3 (int) \$500 K	ENSING T	TON M.	b 208	95			
	Stat Registra	e ar	31. Date filed (Month, Day, Year)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 25 State of Mary Registrar	and / 2872	orent of He tificate of De	ealth and N eath	Mental Hy	giene	10700		
	Physicia	an/	1. Decedent's Name (First, Middle, Last)		imouto or be		2. Date of Dea	Reg. No.	3. Time of Death		
-	Medic Examir	cal	Lucinda Gilot 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death						
_			St Joseph medical Centr	28	Tauson			Bultin	wre		
	Funeral Director		5. Social Security Number 243-50-9592 6. Sex 1 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Months, Day, Year) 4 Oour Feb 12, 1934								
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Loc	eation				10d. Inside City Limits		
	Maryla 28a-f s otified	Director		Baltimo					1 🏿 Yes 2 🗆 No		
	s 23a or sust be no	Funeral D	10e. Street and Number 5809 Hamlin Avenue		10f. Zip Code 21215	5		10g. Citizen of What Co USA	ountry?		
9036	within 72 hours after death with the Maryland gene. er than "natural", or items 23a or 28a-f show er than Medical Examiner must be notified at	ğ	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates.	If	Vas Decedent of Hisp Yes, specify Cuban,	Mexican, Puerto		14. Race - Ame Black, Whit Specify:Bla	e, etc.		
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, Man	l and 2 shou f Health and item 27 is m other traum		19a. Informant's Name/Relationship (Type, Print) Conservil Gilot/Husband					r, City or Town, State, Zi MD 21215	p Code)		
imore			1 Rurial 2 K Cremation 3 Removal from State	b. Place of Dispos cemetery, crem Final J	natory or other place)		Date 6/2011	20c. Location - City or Woodbine			
Balt	permit. Page 'Department or Important: If any injury or once.		21. Signature of Fund on Service Licensee	22.	Name and Address 700 Edmo	of Facilit Bev	erly D Ave. B	cromart	5 ¹ 21223		
-	h sician/		23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cruse on each line. Immediate Cause (Final disease or condition	est,	Approximate Interval Between Onset and Death						
	Medical Examiner	<u>.</u>	resulting in death) a. ue to (or as a c instance) Sequentially list conditions, b.	quence of):	,	3 Days					
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09	cate be executed physician and the burial-transit	dicalE	resulting in death) Last Due to (or as a cons	sequence of);		CERTIFICATION A	PROVED BY MED	KALEXAMINA			
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transi	¥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 🔲		QL.(V.	23d. Date of de Month	livery Day Year			
ds, P.O.	luires that the signed by uld be detact	ed by Pr	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause given	n in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
Division of Vital Records,	The law rec cate has bee page 2 sho	Complet					24a. Was a autop perfo	prior to death?	ntopsy findings available completion of cause of		
/ital	sician: The certificate lirector, pag		25. Was case referred to medical examiner? 1 XX Yes 2 XXNO Hospital: 1 XX I proficer: 2	P ☐ ER/Outpatient	Othors	e of Death (Chec		,			
on of \	To the Hospital or Attending Physician: The li within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Natural 5 Pending (Month, Day, Year)	28b. Time of	28c. Injury at work?			ence 6 Other (Specow injury occurred	eny)		
Division	al or Attending s after death. al Director: After ed in by the fune		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homſcide determined 28e. Place of Injury - At building, etc. (Spe	t home, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,		
2	he Hospital in 24 hours he Funeral ipleted filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examine only one) 3 Certifying Nurse Fractioner T. the Least 1	ation and/or investi	gation, in my opinion,	death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.		
	To the within 2 To the comple	5	29b. Signature and title of certifier N. Desh p castle	M	29c. License no 19460	umber 0 8 2_		29d. Date signed (<i>Mont</i> .)	h, Day, Year)		
			30. Name and address of person who completed cause of death (III	tem 23a) (Type, Pr	7401 OS	iler C	rive	Talesonil	4D 212(H		
	Stat Registra	100	31. Date filed (Month, Day, Year) APR 2 8 2011	J. Sar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 2 Physician/ Dolores Vera Gentes Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Good Samaritian Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Age (In yrs, last birthday 8. Date of Birth **Funeral** 1 □ M 2 🛚 F (Month, Day, Year) June 30,1930 Months Director 339-24-5655 80 Illinois Tune Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natural", or items 2000 any injury or other trainment. 10b. County 10a. State 10c. City, Town or Location Director 1 √Yes 2 □ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6201 Loch Raven Blvd. Apt. 308 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 24 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bohumil Zajicek Victoria Psotka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Gentes Son 2200 Thomas Run Rd. BelAir, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 💹 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 4-30-2011 Timonium, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek FuneralHome MA 9705 Belair Road Nottingham, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final failure Physician/ disease or condition resulting in death) Medical Examiner ation if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Examine or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year 4 Pregnant g Unknown Pregnant at time of death 2 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γq s been siç 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA မ 1 Inpatient After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide within 24 hours are dest To the Funeral Director completed filled by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 5601 Loch Raven Blvd. Jonna na

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
APR 2 9 2011

32. Registrar's Signature

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			For State Registrar		State of M	aryları		Certifica				Reg. N		13	785
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	Funeral Director		5. Social Security No. 215-01-	umber 6. -0924		e (In yrs. la 93		Month	der 1 Year is Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year,) C	rthplace (State	
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	with the 23a or ust be n	Funeral D	10e. Street and Nun		ET			10f. 2	Zip Code	21224			Ditizen of What C		
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Maryland 21215-0036	id be file Mental H arked o	ToE	JOHN PRADICH					\			me (First, Middle, CA BARAN	Maide	faiden Surname)		
Mar	d 2 shoul aith and 1 27 is m er trauma		19a Informant's Name (Relations to Type, Print) LEROY LIPINSKI/30N 19b. Mailing Address (Street and Number or Rural Route Number, City or 7 2413 MUNFORD DRIVE, FALLSTON, MAI							or Town, State, Z ARYLAND	ip Code)				
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disp		Removal from State	CE	emetery,	Disposition (N crematory or C CREM	r other plac		Date 28/2011		Location - City o		YLAND
Baltir	permit, Page 1 a Department of I Important: If ite any injury or of		21. Signature 1 Fureral ervirationnee 22. Name and Address of Facility CHARLES S. ZEILER & S. 6224 EASTERN AVE., BALTIMORE, MARYLA									SON, INC	C.		
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Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a g Unknown	2 Fetal	death	3 Ectopio		су		d	23d. Date of do Month		Year
P.O. 9.	ss that thighed by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to												
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ک Vital	hysicia his certi Il directo	70 B	examiner?	No				atient 3	Oth	ace of Death (Che er: 4 Nursing I	or only one)	dence	6 ☐ Other (Spe	cify)	
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eri(Division	al or Atte s after de I Directo d in by th	Certi	3 ☐ Suicide 4 ☐ Homicide	6 L Could not determined				, street, facto	ory, office		28f. Location (S City or Tow		nd Number or Ru e)	ural Route Num	ber,
9	e Hospita 124 hour e Funera leted fille	Medical	29a. Certifier 1 (Check 2 only one) 3	☐ Medical Exar	ysician: To the best of piner: On the basis of ex rse Practioner: To the	xamination	and/or is	nvestigation, i	in my opinio	on, death occurred	at the time, date a	ind plac	e, and due to the	cause(s) and ma	anner stated.
	To the within To the comp	2	29b. Signature and t			0	XIII O VII O O		9c. License	e number		29 4 . D	ate signed (Mon	h, Day, Year)	
2			30. Name and addre	ess of person who	completed cause of de				1	9072	- y	TI	1611 6	8 66	<u> </u>
7	Stat	te	O'ELEA (Month	h, Day, Year)	32. Registra			Cex	er Ut	y the dge	wood M	lp	2104	0	
	Registra	ar	APR 29	2011 2	news .	gar	P. A. S.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 26, 7:10 A M ETHEL **GOLDBERG** 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Months Days Hours Min 0770571921 **ENGLAND Director** 89 Yrs. 006-26-2326 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8518 CASTLEMILL CIRCLE 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BECKERMAN MORRIS MATILDA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEO GOLDBERG/HUSBAND 8518 CASTLEMILL CIRCLE, PERRY HALL, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 X Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEM PARK 04/28/2011 FALLS CHURCH, VA of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardie on each line. Interval Between Immediate Cause (Final Onset and Death Jarricula Ph sician/ 20ster VIPUS ence disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or se a consequence of) cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): burialnding physiciar Physician/Medical Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ atten for u in the past 12 months?

1 Yes 2 No Month Day Year by the P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate has page 2 2 🗌 No 1 Tes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🔊 Other (Specify) WOSN LY 2 No မ 1 U Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After X Natural 5 Pending ne Hospica, -in 24 hours after death. The Funeral Director: Aft work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar

within 2

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29a. Certifier

(Check

only one 29b. Signature

of certifie

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leted cause of death (Item 23a) (Type, Print)

32. Registrar's

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

N. Charles ST

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TOUSUN MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facilify Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death WEINBERG PARK ASSISTED LIVING N/A ${ t BALTIMORE}$ 9. Birthplace (State or Foreign Country)
GERMANY Social Security Number If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 1 □ M 2 🗓 F Days Min. Month Day, Year 26 84 Yrs. Director 081-20-2915 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A BALTIMORE ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral 3619 GLENGYLE AVENUE, #B8 21215 USA death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ATTORNEY LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ß IRVING GERNER ANNA LOHEIT injury or other traumatic 1 and 2 should be Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH GREENBLUM / HUSBAND 3619 GLENGYLE AVENUE, #B8, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of H Important: If ite ARTINGTON CEMET 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/28/2011 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. any Mout 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE use yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) detached the Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy Hospital or Attending Physician: The After this certificate 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending death. 2 🗌 No Accident Investigation 24 hours after deat Funeral Director; completed filled in by the 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the 29b. Signature and the 29d, Date signed (Month, Day, Year) è

State Registrar 31. Date filed (Month, Day, Year) APR 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** GOLDBERG LILLIAN S. tone) 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner sattimore N/A BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, **Funeral** 1 □ M 2 □ X Months Days 12/23/1919 215-82-6175 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Modical Examine must be natilized at Director 1 □Yes 2 □ No BALTIMORE MD STEVENSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2101 WILTONWOOD ROAD 21153 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER **PHOTOGRAPHY** 4 Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be SAMUEL A.M. SWITZENBAUM **ESTHER** GREENFIELD ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGIE GOLDBERG-OKUN/DAUGHTER 10716 STEVENSON ROAD STEVENSON, MD 20b. Place of Disposition (Name of ARLINGTON CEMETERY Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/28/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lic 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nTri disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 are Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 N 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _ 24 ☐ **X**fo 1 🗌 Inpatient 2 DER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man r of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State

Registrar

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(UV) 32. Registrar

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for Amendal State Amendal	d Item	State of Ma 25 per me,	aryland g914,	d / Depa 04/28/	rtmen 2011 tilicate	t of ⊢ dhb e of C	lealth Death	and N	/lental Hy	gien Reg. N	e loo o i	,	1 0 00	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death										601	5	3. Time of Death		
	Physicia Medic		SIDNEY		HOFFMA	N							L 7	7, 201 ¹	ır	5:15 P M	
	Examir	ier	4a. Facility Name (if no UPPER CHE	ENTER	}	4b. City, Town, or Location of Death BEL AIR					4	c. County of D		D			
	Funeral Director		5. Social Security Num 215-16-64		Sex 1 \square M 2 \square F	e (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birl 01/09/		9.	Birthpl Co <i>untr</i>	ace (State or Foreign y) MD	
	A		Usual Residence of De	ecedent	^							[01/09/.	1921		_	riD	
16	Maryland 28a-f show otified at	Funeral Director	10a. State 1 MD	10b. County HA	RFORD	10c. City	, Town or Loc F (ation OREST	HIL	L					10	d. Inside City Limits	
7	the Ma or 28 e noti	Dir	10e. Street and Number	per				10f. Zip	Code	-			10g. C	Citizen of What	Count		
B	h with the rs 23a nust b	nera	306 WIL	LRICH C	IRCLE, UNI	ТМ			21	050				U.S.A.			
12 July 10036	hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at	by	11. Marital Status1 ☐ Never Married3 ☐ Widowed 4 [12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 1 Yes 2 No Specify:					n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Al Black, W Specify:		c.	
15-(72 hou n "nati	Completed	(Specif	T	Education Irade completed)		16a. Deced	ent's Usua aind of wor NOT use	k done d	ation Juring mos	st of work	ing	16b.	Kind of Busine	ss Indu	ustry	
212	within giene. Ier thai		Elementary/Second	Elementary/Seconday (0-12) College (1-4 or 5+)				ARPEN	,					CONSTR	UCT	ION	
27 land	should be filled within 72 hours aft is and Mental Hygiene. is marked other than "natural", aumatic event, the Medical Exa	To Be	17. Father's Name (First SAMUEL	rst, Middle, Last)	HOFFMAN						ner's Nam NNIE	e (First, Middle,	Maider	aiden Sumame) ANSEL			
(permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Ionce.	10	19a. Informant's Name		*1 '	T/	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 306 WILLRICH CIRCLE, UNIT M FOREST H										
	ye 1 and t of Heal if item 2 or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)									Date		c. Location - City or Town, State			
7−U Baltimore,	mit. Pag partmen portant: y injury ce.		4 Donation 5 Other (Specify) SHAAREI ZION CEMETERY 4/10/2011 ROSEDALE, M 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL, LEVINSON & BROS.									TNC					
L W	B E Ce	13	Muci	roll k	Jugar						OWN - I	ROAD P		SVILLE;	MD	121208	
4	Physician/ Medical		23a. Part 1. Enter the shock, or heart f. Immediate Cause (Fin disease or condition resulting in death)	failure. List only	nplications that caused one cause on each line a. Due to (or as a	211	mo	. 1	e of dying	g, such as	s cardiac o	or respiratory an	rest,			Approximate Interval Between Onset and Death	
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0	cate be executed physician and the burial-transit	edical Ex	that initiated events resulting in death) Las	a conseque	equence of): CERTIFICATION APPROVED BY ME							MEDICAL EXAM	INER				
3760	ficate be g g physicia as the bur	Nedi			'd.						CERT	IFICATION APT III	<u> </u>		1		
. Box 687	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy								23d. Date of Month	deliver	y Day Year				
ds, P.O.	quires that t en signed b		Part II. Other signification of the Control of the	ant conditions	contributing to death b	ut not resu	ulting in the u	Clu	ause giv	en in Part	l. C_					cause of death?	
SIDNEY of Vital Records,	Attending Physician: The law re r death. sctor, After this certificate has be ythe funeral director, page 2 sh	Completed by	Ridne	ey &	lifeas	no	A.	ehe	al	71	aile	Yes Yes			to com ?	sy findings available pletion of cause of	
Vital	/siciar s certif directo	To Be	25.) as case referred examiner?	to medicai N o	Hospital:	ant 2 \square F	ER/Outpatien	+ 3 \(\)	Othe			k o <i>nly one)</i> ome 5 🗌 Resid	donco	6 Other (Se	ocifu)		
-	ing Phy I. After thi uneral o			5 Pending	28a. Date of injui (Month, Day	ry I	28b. Time of injury	28	Bc. Injury work	at ?		28d. Describe h			eciry)		
24 AV Division	l or Attend after death Director: /	Certificate:	Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not determined	be 280 Place of Inju	ıry - At hor :. <i>(</i> Spec <i>ify)</i>	me, farm, stre	M et, factory		Yes 2	⊥ No	28f. Location (S City or Tow			Rural F	Poute Number,	
出	the Hospital or hin 24 hours afte the Funeral Dir mpleted filled in I	Medical	(Check 2 ∟	Medical Exan	ysician: To the best of niner: On the basis of ex	kamination	and/or invest	igation, in r	ny opinio	n, death c	occurred a	t the time, date a	and plac	e, and due to the	ne caus	e(s) and manner stated.	
土	To the within To the compl	Σ	only one) 3 L 29b. Signature and title		rse Practioner: To the	best of my	knowledge, d		License		e and plac	ce, and due to th		ate signed (Mo			
			30. Name and address	s of person who	completed cause of de	eath (Item	23a) (Type, P	rint)	10	06	550	044		111	\mathcal{H}	-	
(i0			I. MIKIT	YANSKAY	A, 500 UPP	ER CH	ESAPEA	KE D		, BE	L AII	R, MD 2	2101	4	'		
	Sta Registra		31. Date filed (Month, L	Day, Year) APR 28	2011 32. Rygistra	r's Signatu	B. 4	arke	f								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Yvonne Marie Humphreys 0530 عاق ا April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Haure de Hartora Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Hours (Month, Pay, Year) 925 Mary Land 85 Yrs 219-18-1653 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2168 Historic Drive 21050 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Order Editor 9 Koppers Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irwin J. Charbonnet Bernice B. Aleshire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Diane Y. Newton (Daughter) 16 Iler Lane, Chesapeake City, Maryland 21915 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 29, 1 Burial 2 XCremation 3 Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 \mathbf{Bel} - Air Testerman 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air (M01543) 3 Newport Drive, Forest Hill, Maryland 21050 Signature of Funeral Service Licensee Jeffrey R. 23a. Part 1 Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): 4 WKS **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Month 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Varsing Home 5 Residence 6 Other (Specify) 2 1100 မှ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number MD Whan D 32609 4/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kammam Miham 700 1164 Kev. evalution St Harrede Grave MB 21078 1100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Medical Exami	ner	Berrie Wood Ha 4a. Facility Name (if not institution				45 City Town	or Location of D	Apr	il 19, 20	11 4c. County of	Dooth	1505 hrs
		2446 Thomas Run Ro		mber)		Bel Air	of Location of D	ealli		Harford	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Y			ate of Birth	(MM/DD/YYYY)		lace (State or
Director		215-42-5599	1 M 2 F		68 Y	rs. Months D	ays Hours	Min. Ma	rch 9	, 1943	Foreign Count	^{ry)} Maryland
Þ		Usual Residence of Decedent 10a. State 10b. County		Iton City	, Town or Loca	tion					140	Od. Inside City Limits
F. P. A.		Maryland Harfo	ord		Bel Aiı							Yes 2 X No
te Maryland or 28a-f show any fied at once.	Director	10e. Street and Number			DCI ALI	10f. Zip Code	,	_	10g.	. Citizen of Wha		
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or deat	튑	1 Never Married 2 M 3 Widowed 4 X Div	1 X Vee	2 No				orto reloan,	010.7			
urs affe		15. Decedent's Education (Spe	vorced If Yes, Give Yea or Dates: 1 C	65- 197 de completed)	7()	Yes 2 X I		of work don	ne 1	Specify: 6b, Kind of Busi	Whit ness/Indu	
72 hor	ete	Elementary/Secondary (0-12)			during r	nost of working I	ife. DO NOT use	retired)				
within iene.	Completed by		4		Equipn	nent Rep				Mechanic	cal F	Repai
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Bec	17. Father's Name (First, Middle Grover Hamilto	•							iden Surname)		
212 212 212 212 212 212 213 213 213 213	2	19a. Informant's Name/Relations	hin (Type Print)	Dead are all	19b. Mailir	ng Address (Str	Kathry eet and Number			er, City or Town,	State, Zi	p Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		Mrs. Elizabeth	Fleming	Friend)		Mitchell		perde				
or Heal		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal fro	om State	Place of Dispo crematory or o	sition (Name of other place)	cemetery,	Date Oril 2		20c. Location - C	City or Tov	wn, State
Baltimore, permit. Pages la Department of He Important: Il ite injury or other th		4 Donation 5 Other Si	pecify:		Rei	- Air		2011	·	Forest H	Iill,	Maryland
Baltimore permit. Pages 1 Department of F Important: If injury or other		21. Signature of Funeral Service	Licensee Jeffr	ey R. Tes (M015/3)	termarî ²	Name and Addre	eral Chap	el & Cr	ematic	n Şerviç	E Bel	- Air
Physician	寸	23a. Fart I. Enter the disease, or	complications that ca	sused the death.	. Do not enter	the mode of dyin	g, such as cardi	ac or respira	atory arrest	, shock, or hear	t A	Approximate Interval
/Medical		failure List only one cause Immediate Cause (Final disease		ensive A	Atheros	cleroti	c Cardi	ovasci	ular l	Disease		Between Onset and Death
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Box 68760, e death certificate b the attending physicate be dor use as the burden of the attending physicate burden of for use as the burden of the burden o	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o	outcome of pregr		-4-1 do -41 3	Ectopic pre	gnanov		23d. Date of de	elivery Day	Year
x 687 th certifications tending	iciar	past 12 months?	4 Pregna	ant at time of de	ath -	etal death 3 ther (Specify)	Ectobic bie	griaricy		WORTH	Day	real
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Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been side in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	티							-	autopsy performe Yes 2	ed? dea	ath?	pletion of cause of
tal Recian: The certificate		25. Was case referred to medica				26, Pla	ce of Death (Che				Yes	2 No
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n of ding Pl		27. Manner of Death 1 X Natural 5 Pend	28a. Date (Month,	of Injury Day,Year)	28b. Time of	Injury 28c, in	jury at Work?	28d. De	escribe how	v injury occurred	1	
Division of population of a population of a strength of a population of a strength of	Certification:	2 Accident Inves	stigation 28e Place	of Injury - At ho	ome farm stre	et, factory, office	Yes 2 No	28f Lo	cation (Stre	et and Number	or Rural I	Route Number, City
Div ital or irs afte			d not be mined (Specify)	or injury 7 km	ono, iaini, one	ot, lactory, office	Danding, oto.		Town, State		or real art	reduce realition, only
5 E P S		29a. Certifier 1 Certifying Pl	nysician: To the best									
To the Hos within 24 h To the Fus	Medical		miner:On the basis of and manner st	f examination ar ated.	nd/or investiga			ed at the tim				
2.1	≥	29b. Signature and title of certifie	Г				nse number C.M.E.			9d. Date signed April 20, 201		∪ay, Year)
Oxbein	-	30. Name and address of person	who completed cause	e of death (Item	23a)						•	· -
\mathcal{D}		Donna M. Vincenti, MI				1 Penn Stree	et, Baltimore,	MD 212	01			
Sta Registr		31. Date filed (Month, Day, Year) APR 29 2011	32. Re	gistrar's Signatu	re			•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician aine 7 2611 nman /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🗓 F 1-5-1969 220-72-1500 MD 42 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√√No Director other traumatic event, the Medical Examiner must be notified MD Garrett McHenry 10f. Zip-Code 10g, Citizen of What Country? 10e. Street and Number 21541 United States 175 Pysell Road Apt. 10 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛚 No Specify: <u>ک</u> If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Embroidery Company 10 years Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Lubking Russell Klunk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (father) 2829 Benson Road Finksburg, MD 21048 Russell Klunk Department of Healt Important: If item 2 any injury or other 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Carroll Cremation 4-29-2011 Hampstead, MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility re of Funera 21. Signa Service Licensee ELINE FUNERAL HOME 21136 MD11824 Reisterstown Rd. Reisterstown, J. Wayne Osterling diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, litre. list only one cause on each line. Part 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiration ailure disease or condition resulting in death) / /Medical Due to (or as a consequence of): **Examiner** heumon Sequentially list conditions, if any, leading to immediate cause. Et al. Cause (Disease or injury that initiated events are this independent) act Examine Due to (or as a consequence of) for use as the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No Yes 2**X** No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No Hospital: Inpatient 3 🗆 DOA 2 ER/Outpatient မ Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Natural 5 Pending investigation Injury 1 🗌 Yes death. Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one)

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. I Records, Division of Vital 24 hours

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES DOD

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

1. Decedent's Name (First, Middle, Last)

Paul

Lorien Columbia

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

Bernard Hitchens, Sr.

7. Age (In yrs. last birthday

death with the Maryland "natural", or items 23a or dical Examiner must be Department of Healt Important: If item 2 any Injury or other

Baltimore, Maryland 21215-0036

hysician /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-tran

Division or Vital Records, P.O. Box 68760,

216-24-4110 82 08/09/1928 Usual Residence of Decedent 10c. City, Town or Location 10a. State r 28a-f show notified at MD Baltimore Catonsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 203 Oak Forest Place 21228 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Truck Driver</u> Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carroll Edwin Hitchens Ethel M. Hobbs P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul B. Hitchens, Jr./son 1730 Gablehammer Road Westminster, Maryland 21157 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 05/03/2011 Hanover, Maryland 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signa up of Funeral Service Live M00957 4112 Old Columbia Pike Ellicott City, MD 21043 Marita Momoo 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Due to (or as a consequence of): HEART CONGESTIVE FAILURE Securitially list cardifors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) LORONARY APTERY DISEASE Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 DISORDER 1 | Yes 2 No 3 | Probably 4 | Unknown Completed DSTEDPORDSIS 24a. Was an perform CHRONIC KIDNEY 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1-Natural the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Ecritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0069962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 6334 CEDAR LANE, LORIEN, COLUMBIA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Days

2. Date of Death

8. Date of Birth (Month, Day, Year)

April

Day

4c. County of Death

Howard

Black, White, etc.

27,

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

WEEKS MONTE

DAYS

Day

24b. Were autopsy findings available prior to completion of cause of

2□No

death? 1 Yes

1 ☐ Yes 2 ☐ No

Maryland

White

1:15 P M

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d, Date signed (Month, Day, Year)

4-27-2011

29c. License number

D37142

Geoffrey Coleman, M.D. 1355 Piccard Drive Suite 100, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** P.M22, 2011 April 8:30 Rose Marie Hurdle /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Summit Park Health and Rehab Catonsville If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Aug 14, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🖾 F 75 Virginia Director 577-50-9049 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examinating the notified at 1 ☐ Yes 2 🗓 No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö death with USA 21042 23a 3177 Elmmede Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status and 2 should be filed within 72 hours after 1 ☐Yes 2 XI If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married White ō 1 ☐ Yes 2 🛛 No Specify: 2 3 X Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) New Carrollton i and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government City Council Woman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Cecelia Brooks ပ Maurice Edwin Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If item 27 is any injury or other trau once. 3177 Elmmede Road; Ellicott City, MD 21042 Anne Coakley Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham Vet Cemetery 5-2-2011 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwah Witzke Funeral Home of Catonsville, Inc. 21. Sign we of meral Service Lice 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EMENTIA Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** SENILII Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Box 68760, Division of Vital Records, P.O. filled in by completely within 24

altimore, Maryland 21215-0036

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3955 TAN MOS 31. Date filed (Month, Day, Year) -32. Registrar's Signature 29

and manner stated.

ATTENDING

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00056948

Suite 204 BATIMORE NO

29d. Date signed (Month, Day, Year)

20/1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20^{Year} 2:15[₽] м Kenneth R Hommerbocker April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death 99 Timber Ridge Dr. Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** Days (Month, Day, Year) 11-9-1930 1 **X**M 2 □ F Months Hours Min Director 213-26-9140 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Examiner must he matical and injury or other traumatic event, the Medical Examiner must he matical and injury or other traumatic event, the Medical Examiner must he matical and injury or other traumatic event. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 💥 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 99 Timber Ridge Dr. 21157 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1X Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify. Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Tile Setter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Hommerbocker Mabel Morrissette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Hommerbocker-wife 99 Timber Ridge Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 4-26-11 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signa pe of For eral Service Lice 22. Name and Address of Facility Fletcher Funeral Home Morris 254 E. Main St., Westminster, MD 21157 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) law requires that the death certificate be executed Hypertension attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hyperlipidemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death Month Day Year 2 No tor: After this certificate has been signed by the atthe funeral director, page 2 should be detached 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinsons 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Hospital or Attending Physician: The performed ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifie **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO065246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KXIV Rd., Westminster, MD 912 Washington

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per in g914 4-29-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 26 Month 1 Physician/ 82 PM 00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death +IMORE 8. Date of Birth 9. Birthplace (State or Foreign Country) If Under **Funeral** 7. Age (In yrs. last birthday) 1 M M 2 🗆 F Days 5-488 Months Hours 5 Yrs. Director 28a-f shov 10a, State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified balli more 1 🗌 Yes 2 🔀 o Gwynn Oak Hmore 10e. Street and Nu 10f. Zíp Code 10g. Citizen of What Country? Funeral 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Wo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes Yes Yes, Give Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: 3 Widowed 4 Divorced "natural" Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DANDT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Conday (0-12) College (1-4 or 5+) Be Name (First, Middle, Last) 2 be nomas lohnson Page 1 and 2 should 19a. Informant's Name (Relationship (Type, Print) 19b. Mailing Add ss (Str. unnson other Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 Department of Important: If it any injury or o tof eadowrid 1 Burial 2 Cremation 3 Removal from State or other place 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Vices 40. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph, sician/ 400 TIC disease or condition rupture Medical resulting in death) Due to (or as a consequence of): Examiner edia stinitis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine left anterior descending or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury Anomalous that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day page 2 should be detached the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🗷 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 3 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) and address of person who completed cause of death (Item 23a) (Type, Print) Greene 31. Date filed (Month, Day, Year) State 9 Registrar

Registrar DHMH 17 Rev 1/2001

11595

State

one

29b. Signature and title of certifier

Charles R.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3altimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not Institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 M 28 F 73 **Director** 220-38-5506 July 30, 1937 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Department of Health and Mental Hygiene, interportant, or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. once. 1 ☐ Yes 2X No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral 6 Stoneleigh Court 21014 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify If Yes, Give Year or Dates Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Medical Researcher Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filk ment of Health and Mental Hy tant: If item 27 is marked oth Be Paul Hess Jaeger မ Esther Stokes Silver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Rider Hill Road, Ruxton, John Jaeger / Brother MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4-27-11 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 Funer Service Licenses caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or compli shock, or heart failure. List only of Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as t IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year detached for Pregnant at time of death 5 Other (specify) Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ate has been signed | page 2 should be de Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital 2 No 1 Inpatient 2 1 Tes 3 DOA 2 ER/Outpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

မှ

asun 31. Date filed (Month, Day, Year)

d title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature

32. Registrar's Signature Darke

State

Registrar

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medic		1. Decedent's Name	e (First, Middle, E/CT		tnus	T						2. Date of D	eath Z	ay 2	Year	3. Time of Death <i>O1:27 A</i> M	
Examin	er	4a. Facility Name (if SHOCK T	not institution, RAUNI UNIVE	give street a	and number	MA	vylan	41	b. City, Town Balti		ocation of Dea	th	4	c. County	of Death		
Funeral Director		5. Social Security No. 220–36–18	umber	6. Sex 1 X □ M 2	7. /	Age (In yrs.	last birtho	day)	f Under 1 Yellonths Da		If Under 24 Hrs Hours Min		rth ay, Year)	939	9. Birth	place (State or Foreign htry) MD	
yland •f show ed at	ctor	Usual Residence of 10a. State MD	Decedent 10b. County Carro	1		10c. C	ity, Town o	or Locati								10d. Inside City Limits 1 ☐ Yes 2 🔏 No	
death with the Maryland items 23a or 28a-f show ner must be notified at	Funeral Director	10e. Street and Num	nber				110.		10f. Zip Coc 2177				10g. Citizen of What Country?				
death wit items 23 ier must	Funer	5166 Per	ry Road	12. W	as Deceden		I.S.	13. Was	Decedent of	of Hisp	panic Origin? (S	Specify Yes or No	acify Yes or No- 14. Race - American Indian,				
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be filed within 72 hours after ental Hygiene. ked other than "natural", or ic event, the Medical Exami	Completed	(Spec	15. Deceden ecify only highes onday (0-12)	st grade con		r 5+)	(0	Give kina	t's Usual Oc i of work do lOT use retir	ne dun	on ing most of wo	orking	16b.	Kind of Bu			
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nit. Page 1 and 2 should be flied within 72 hours artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical e.	10											Code)					
		Elizabeth		(spou	ıse)	20b.	51 Place of D	66 P	erry on (Name of	Rd.	, Mt. 1	Airy, MD	217	771		own, State	
permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		1 X Burial 2 [4 Donation 21. Signature of Fur	5 Other (S)	pecify)	val from Sta	IC.		ew M	lemori	al	5-3	3-11 ight Fun		cesvi			
permi Depa Impo any it		▶ Parge	Haigh	+ He	rber			P.0	. Box	19	5 Syke	sville,	MD 2		100	TANTAL!	
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
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is as	<u> </u>	resulting in death) L			,	a consequence of): ON VEHICLE ACCIDENT / MULTITRALMA											
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n		1		1 2 🗆 Fe	tal death		ctopic pregr			-			te of deliv		
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Physi r this o	은	1 ✓ Yes 2 ☐ 27. Manner of Death	No No		1 Inpa	atient 2	ER/Outp		3 LI DOA	Other: njury at		Home 5 Res				()	
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the Hospi nin 24 hou the Funer	Medical	(Check 2	Medical Ex	caminer: On	the basis of	examination	on and/or i	nvestigat	tion, in my o _l	pinion,	death occurred	and due to the c	ause(s) a and plac	and manne e, and due	er as state to the ca	ed. use(s) and manner stated.	
To with		29b. Signature and t	title of certifier	Lo	m	l.	m.	D,	29c. Lice		wmber 880	8	29d. D	ate signed	2.7	Day, Year)	
		30. Name and addre	Sav		MD: a	12. S	5-6ra			B	autimo	vo.MD	9	1501			
Stat Registra	e ır	31. Date filed (Month	PR 2 9	2011	32 Regis	trar's Sign	ature										

11-03194 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John Francis Kline 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** 1549 hrs John Francis Kline April 26, 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** 9939 Bird River Road Middle River If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 215-32-9481 eptember 5,19\$5 Country) Maryland 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits in y 10a. State 10b. County 10c. City, Town or Location 1 Yes 2X No Middle River Md. Balto. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 21220 這 9939 Bird River Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2X No Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify White þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Excavation Co. Operating Engineer 8th other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John A. Kline Be Margaret Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9939 Bird River Road Middle River, Md. 21220 Spouse Mary H. Kline If item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date timore, crematory or other place)
Gardens of Faith 1 X Burial 2 Cremation 3 Removal from State 4-30-2011 Balto. Md. 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Fur Nottingham, Funeral Home am, Md. 21236 705 Belair Road Cu CVV 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and **iMedical** Death a Contact Shotgun Wound of Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED g physician a AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred 28b. Time of Injury Certification: Subject shot self Natural **FOUND** Director: 5 Pending 1 Yes 2 ✔ No Apr 26, 2011 1540 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 9939 Bird River Road, Middle River, MD (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sal 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E April 27, 2011

31. Date filed (Month, Day, Year) State Registrar

/DHMH 17 Rev 1/2001

OCME 2006

Carol Allan, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A DE Physician/ 2 Day 3:52 pm 2011 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITA Baltimore gnes 7. Age (In yrs. last birthday) Yrs. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-22-1580 1 □ M 2 🕶 F Months Days Hours Min. **Director** Usual Besidence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material and once. 10a. State 10d. Inside City Limits Director Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 65 Kind of Business Industry (Give kind of work done during most of working ify only highest grade completed samson PO NOT use retired) College (1-4 or 5+) ter; a orKer High Be 2 e n, State, Zip Code) and 20a. Method of Disposition 20b. Place of Disposition (Name of cameter), crematory or other 1 🖫 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funera Service Licensee greene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final personascular accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner PillAtion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and deed be detached for use as the burial-transit pertension that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death this certificate has been signed by the raid irrector, page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Tyes Hospital or Attending Physician: Division of Vital completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and itle 29c. License number 24071 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IbeRm: Nt 900 AtON 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Apr 21 Physician/ Day 2011 Bobbie Ann King 5:42 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. (Month, Day, Year) Dec 2, 1957 1 □ M 2Xx F Months Davs Hours **Director** Dec 212-72-9882 53 Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Examiner must be notified 1 Yes 2XX No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 14 Monroe St, #302 20850 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō ģ 1 Never Married 2 Married 1 Yes If Yes, Give XX No Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: Specify: "natural", Completed 3 Widowed 4 XXDivorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Frank Lewis Helen Johnson permit, Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Lewis Tucker Sister unk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XXCremation 3 XXRemoval from State 4 Donation 5 Other (Specify Bayview Crematory Apr 26, 2011 Baltimore, MD Futterni Service U 22. Parnekan Pundersa Pf Facility, P.A. 21. Signal 426 Crain Hwy S., Glen Burnie, MD 21061 Gregory Kink 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Athersclerotic Cardiovascular Decease Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Renal Failure Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2XX No the 9 Unknown detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4XX Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 * X No 1 Yes 2 🗌 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes 2 | No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After 1 XX Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation
6
Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif

Registrar

State

31. Date filed (Month, Day, Year)

29

DHMH 17 Rev 7/2009

dress of person who completed cause of death (Item 23a) (Type, Frint)

Scott Freedman MD 9901 Medical Center Dr, Rockville, MD 21050

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 25 Day 2011 Year Physician/ 10:15 Pm Kee Dorothy Nelson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 801 Stiles Ct. Joppa 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. Nov. 27, 1 M 2 XF Months Year 1918 Maryland Director 92 217-07-2295 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🕇 No Maryland | Harford Joppa 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 801 Stiles Court 21085 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. White Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nellie Mae Burton James Martin Amoss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Stiles Court, Joppa, Maryland 21085 Barbara Wolfe / Daughter 20a Method of Disposition 1 Donation 5 Orber 6 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jarrettsville Cemetery 4-29-11 Jarrettsville, MD Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Demento Physician/ year disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Day Pregnant at time of death 9 Unknown Unknown is been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page Hospital or Attending Physician: The this certificate I Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 2 Accident 3 Suicide work?
1 Yes 2 No iniury 5 Pending after death.

Director: Aff
in by the fur Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35012 (Type, Print) Chesaperke Med. Conter. Bel Air, Md 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Kerin 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

ال

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2:10 P M 2011 Kelly Margaret 21 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lookabout Manor Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 XF Hours OH Country) 292-16-0364 12-8-1919 91 **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1510 Stone Rd. 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No 11. Marital Status ral", or iten Examiner r 14 Bace - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 XWidowed 4 ☐ Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 8 Housewife if Health and Mental Hygie item 27 is marked other other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Musci Anna Passa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia Boswell-daughter 2204 Hopi Ct., Westminster, MD 21157 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-25-2011 Marriotts ville, MD Crestlawn Mem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home hand 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical The law equires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Live Birth 2 Line and Cash
Pregnant at time of death
Unknown in the past 12 months? Year Day the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension, Congestive Heart Failure Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No he Funeral Director: After this certificate in pleted filled in by the funeral director page 1 ☐ Yes 2 🔀 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣No Other: မ Asst 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 1 Katural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Living 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier 💢 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl 29c. License number ZCII 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Phillip Ruzbarsky,

31. Date filed (Month, Day, Year)

MD,

125 Airport Dr., Westminster, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 April Physician/ Barry John Lietuvnikas 23, 5:30 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 521 MacIntosh Circle Harford Joppa 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea OCt. 24, **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months 1960 Maryland 218-84-1300 Director 50 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 X No Maryland Harford Joppa 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 521 MacIntosh Circle 20185 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or 1 ☐ Yes 2 🛣 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 🛭 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Systems Analyst Baltimore City Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Ernest Lietuvnikas Mary Catherine Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4818 Clermont Mill Rd. Pylesville, MD David Lietuvnikas / Brother permit. Page 1 and 2:
Department of Health
Important: If item 27
any injury or other tr
once, 20a. Method of Disposition 20b. Place of Disposition (Name of April 27, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Evans Funeral "Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2011 Bel Air 21. Signature of Funeral Service Licens

22. Name and Address of Facility
Evans Funeral Chapel & Crema
3 Newport Drive Forest Hill

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service - BelAir Maryland 21050 Approximate Interval Between Onset and Death Physician Myocardial infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 13 years Atheroscurotic cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 15 years Diabetes Mellitus type II burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Renal dicace stage 5 years Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hyperlinidemia cate has page 2 s autopsy perform Yes 2 N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined filled in 24 hours a Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature anentitle of certifie 29d. Date signed (Month, Day, Year) D0061154 4/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Teaethe Louderback, MD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Sign

615 w. mac Phail Rd

20Co

BRI AIR, MD ZIOIY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Magdeline Letts April 9:28P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stella <u>Maris Hospice</u> Timonium 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) July 1, 1927 Months Hours Min 214-22-2685 **Director** 83 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No Balto. Kingsville Md 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 11827 Chapman Road 21087 USA items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc ò 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify. White If Yes, Give Year or Dates 'natural", Widowed 4 ☐ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 David J. Boyle Agnes Appel or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 11827 Chapman Road Joseph M. Letts Kingsville, Md.. 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 15-2-2011 Owings Mills, Md. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral HOme any tet 9705 Belair Road Nottingham 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ___ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner crascitially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of); the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy APRIL in the past 16 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) ed by the a detached f g Unknown g 🗌 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗆 Yes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law autopsy perform certificate l Yes LETTS 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 441 M **Physician** ee 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min 214-62-5292 58 Mr. **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10a. State 10b Count 10c. City, Town or Location 1 Yes 2 □ No Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code õ "natural", or items 23a o USA HOLDFOOK 2/202 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) /Şecondary (0-12) is marked other than 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Foster ၉ Eliza beth or other traumatic 19a. Informant's Na e/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Keisterstown, 140 Main brook 20a. Method of Disposition 1 ☐ Burial 2 Crem 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, MD Cremation 3 - Removal from State -30-2011 Sther (Specify) 4 Donation 22. Name and Address o Facility March 21. Signature of Fu ral Service Li 1101 E. North Ave. Baltimore, 21202 MD 23a. Part 1. Epter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Oue (or as a consequence **Physician** 1eumonia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physiciar Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached Unknown Division of Vital Records, P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 2 No 1 Yes 2 🗌 No certificate or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \square Nursing Home 2 No 2 ER/Outpatient 3 🗌 DOA Inpatient 5 Residence 6 Other (Specify) this 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident (Month, Day 5 Pending investigation death. 1 Yes 2 No Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 24 hours after on Euneral Direct 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASNUY PA HelgeSon 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month Registrar's Signature

H DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me, g914,04/2872011d18 Hygiene 1 - For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LANC. MILLER 125 Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ☐ M 2XXF Days Hours 75 217-32-8047 1/17/1936 Director MD Usual Residence of Decedent 28a-f shov 10b. County ä 10a. State 10c. City, Town or Location 10d. Inside City Limits Director be notified MD Frederick 1 Yes 2XXNo Mt. Airy 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **Examiner must** 13506 Bottom Road 21771 USA or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes **XX** No Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes XX No Specify: If Yes Give "natural", Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Community Planning Development Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Gordon Miller Elizabeth Heidl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13506 Bottom Road Mt. Airy, MD 21771 Mrs. Susan Henry / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial XXX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/09/2011 Glen Burnie, MD Funeral icensee Sign 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Part 1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ WHET ASTATIC HUENOCAR CINDUA disease or condition resulting in death) Medical Examiner STRVCTIVE Eagus Hally list so . Blocs ner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami that the death certificate be executed that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of). attending physician for use as the burial CERTIFICATION APPROVED BY Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month signed by the a g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENIA TOMA Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No I or Attending Physician: The after death.

Director, After this certificate I 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury a Natural 5 Pending Division work? 1 ☐ Yes 2**X** No. Subject fell 04/04/2011 Unknown X Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Doctor's Office** 28f. Location (Street and Number or Rural Route Number City or Town, State) 10710 Charter #110, Columbia, MD 21044 4 Homicide determined Dr., Hospital within 24 hours To the Funeral Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) KEVINETHI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMH 17 Rev 7/2009

State Registrar BALTIMERA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Kose 11:34 A M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randerdie Baltimore Novth wis 8. Date of Birth (Month, Day, Feb. 7, 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday Days Min. 1 🗆 M 2 🔯 F Hours $\overset{\text{Year}}{19}14$ Maryland Director 97 214-30-4160 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 3 Surrey Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ith and Mental F 27 is marked of traumatic ever permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ္ Viola Ernest Rose (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Memphis Daughter Surrey Court Reisterstown, Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🖺 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cem 4/28/2011 Woodlawn, Maryland re of Funera Service Lieensee . Signa 22. Name and Address of Facility 11824 Reisterstown Road J. Wayne Osterling ELINE FUNERAL HOME Reisterstown, Maryland 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a cons ruence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown CHI CAD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) DO05061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 0730A <u>Jerome J. Minnincks</u> April 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake BelAir Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F Months Days Hours (Month, Day, Year) Yrs Director 216-07-0266 96 Maryland <u>September</u> Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. 000 0730, an Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 2311 Cloverdale Drive 21047 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceding Even in 0.3.

Armed Forces?

1 △ Yes 2 □ No

If Yes, Give
Year or Dates. 1942–1945 Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. within 7 Elementary/Seconday (0-12) 10th College (1-4 or 5+) Milk Salesman Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental F မ Russell Minnicks Marie Krejci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Leuba DTR. 2311 Cloverdale Drive Fallston, Md. Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 4-30-2011 Parkville, Md. 22. Name and Address of Facility Schimunek Fuenral Home 9705 Belair Road Nottingham, Md, 21236 21. Signature of Fund at Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy sate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 400 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PNo 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

JERONE

MINNICKS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 10 State of Maryland, Pepartment of Health and Mental Hygiene 2 0 | | For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year APRTI ROSE LUCY MARTINEZ 2011 Medical 9:11A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 20, 1917 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 6 Sex 7. Age (In yrs. last birthday) 1 M 2 XXF Hours 093-10-4837 93 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10h County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No NY MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral Lee Place USA 21702 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed 3XX Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Garment 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental F ၉ Anna Vozza permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic Florindo Buonocore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Lee Place, Frederick, MD 21702 Juliann Martinez Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green-Wood Cemetery Apr 30, 2011 Brooklyn, NY 21. Sign Ju f Funeral Service L censoè 22. Name and Address of Facility
Fink Funeral Home, P.A. Greage M01148 426 Crain Hwy S, Glen Burnie, MD 23a. Part 1. Enter the disease or or shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final Ph sician/ COPD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner months Recurrent UTIS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) month Cause (Disease or linjury Sepsis Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Macular Degeneration 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autopsy performed Yes 2 No this certificate ☐ Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA Director; After the in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, 1 Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. lace of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person

Nilay

31. Date filed (Month

Thake

APR 29

D.O

2011

S. Main St.

40070147

Suite 202

Family Physician

who completed cause of death (Item 23a) (Type, Print)

1502

25/11

Mant Ary, MD 21771

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ April Donald Eugene McDonough 24, 5:45 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehab & Nursing Center Sandy Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 X M 2 D F Hours December 18, 1928 New York 82 **Director** 183-22-4804 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** be notified Maryland Montgomery 1 Yes 2 X No Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3616 Raymond Street 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates.1946-1949 dical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Information the Me Elementary/Seconday (0-12) College (1-4 or 5+) T.V. Director Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 27 is marke traumatic Joseph Andrew McDonough Margaret Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Mary Regan McDonough/Wife 4125 Sandcastle Lane, Olney, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott April 29, 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery
Crematorium. Inc. ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee Ko M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ENDSTAGE MOVEMENT DISORDER WITH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DEBILITATION YEARS PROGRESSIVE ASSOCIATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last signed by the attending physician I be detached for use as the buria Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CERRETSRO VAGLULAR DISEASE 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown CARCINOMA PROSTATIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? YERIPHERAL VASCULAR 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Records, Division of Vital ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th completed filled in by the To the I within 2 To the I

511 State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signatu

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one

29b. Signature and title of certifie

HOWE

ARTIZAN ST

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

WILLIAMSADET

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY C917 /7/08/2011 JH Health and Mental Hygiene? = State Registrar Certificate of Death 2. Date of Death 27bay 1. Decedent's Name (First, Middle, Last) Physician/ Margaret Virginia Myerly April 2011 28, 4:28 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Oregon **Funeral** 8. Date of Birth 1 □ M 2XXF Months Days (Month, Day, Year Director 91 215-07-1603 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2XXNo Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 3270 Charmil Drive 21102 "natural", or items edical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes ŽXX No Specify: 3XXWidowed 4 □ Divorced Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Seamstress Sewing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of ၉ Ernest Koppen Mamie Wink permit. Page 1 and 2 should t. Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda C. Funk (Daughter) Peanut Drive, Hanover, Pennsylvania 17331 Date 30, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) any injury or 1XXBurial 2 Cremation 3 Removal from State Apr. 4 Donation 5 Other (Specify) Greenmount U.M.C. Cem 2011 Greenmount, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Enter the disease, or complic to as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh ck, or heart failu Imme iate Cause (Final ck, or heart failure. List only one cause on each line. Interval Between Onset and Death 5 Chemic Bowe Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗷 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending injury 2 Accident
3 Suicide Investigation 1 Yes 2 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 00059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIN 295 30

Registrar

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 4PRIL 08.30 A M Mary Joan McGowan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL ST. AGNES BALTIMORE 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthday If Under Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, 1 🗆 M 2 🔀 F 84 Director 220-18-5816 Jan. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2 Summit Hill Court T3 21228 **IISA** permit. Page 1 and 2 should be filed within 72 hours after death Nopartment of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☒ No If Yes, Give \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Specify Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis X. Buser Hilda Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Forest Avenue; Catonsville, MD 21228 Donna Machin Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place)
New Cathedral Cemetery 4/26/2011 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 . Signat re of Hurieral Service Lion 26 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician ACUTE CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown Day Year 1 Yes 2 D been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, DIABETES. 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown CORUNARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. e Funeral Director: After this certificate has performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified D0062634 MD APRIL 18,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN AWAN ,MD 10796 HICKORY RIDGE RD COLUMBIA 31. Date filed (Month, Day State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death t's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ P 011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson Age (In yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Month Day 196 1 🗆 M 2 💢 F **Director** or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral USA items 23a 21216 Tman Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc Armed Forces 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event than "natural", or þ Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Genes Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) any/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First Middle, Last) 18. Mother's Name (First, Middle မ erov Informant's Name/Relationship (Type, Print) Sister Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ballo. mD 21229 lerie Baltimore, 20a. Method of Disposition

1 → Burial 2 □ Cremation 3 □ Removal from State 2014 Rlace of Disposit 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fure al Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final erforated Physician/ disease or condition Medical resulting in death) Du to (or as a consequence of) Examiner anome Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To . Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred completed filled in by the funeral 28c. Injury at work?
1 Yes 2 No 1 Naturai iniury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Gilbert Grayson Owen Sr. 2011 2:05 p April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days (Month, Day, an. 22 1 🛛 M 2 🗍 F Months Hours Min Year) ^{Country)} Virginia Director 223-30-2652 85 1926 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director r 28a-f sl notified 1 Tes 2 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1905 Philadelphia Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grover Marvin Owen Celia Jane Reedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troonce. Barbara S. Owen / Wife 1905 Philadelphia Road, Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 XRemoval from State Donation 5 Other (Specify) 5-2-11 Owen Family Cemetery Mouth of Wilson, VA 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Þ 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhagic stroke Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner 7 Zyhrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes ≥ L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Be 26. Place of Death (Check only one) Hospital 2 **X**No ပ 1 🗌 Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier Medical Doctor D71096 April 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESTADICLA 500 Upperchesepeake Dive Bel Air, MD 21014 ANGELIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 17 Rev 7/2009

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:23 PM 2011 OSE OHE APRIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARI HOWARD COUNTY GENERAL HISPITAL -UMBIA Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖳 F Months Hours Min 07/104/11928 214 24 3415 Director 82 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2901 Eaton Square 21043 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give 3 🕅 Widowed 4 🗆 Divorced Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John H. Huggins Rose Schmitt 19a. Informant's Name/Relationship (Type, Print)
Erin O'Doherty- Daug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1807\ Beaufort\ St.\ Laramie,\ WY\ 82072$ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ò Baltimore Washington 4/22/2011 Laurel, MD injury (4 Donation 5 Other (Specify) 22. Name and Address of Facility atoms ville, inc. 1630 Edmondson Ave. Catonsville, MD 21228 Signature of Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ WITH ASPIRATION EME SIS disease or condition resulting in death) Medical Due to (or as a consequence of Examine 2 HOURS NITESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an After this certificate has performed 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 1 Tyes ျှ 1 Natient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatle Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Prifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUDH CEDAR COLUMBIA, MD Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ James Monroe Patrick April 28^{ay} 201°1 2:40pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 2170 Daisy Road Woodbine Howard If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Year 1937 1 X M 2 - F Month, Day 73 213-36-2968 June Director MD Usual Residence of Decedent 28a-f show 10a. State "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Woodbine MD Howard 1 Yes 2 X No 10f, Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral 2170 Daisy Road 21797 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Dairy Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Belden David Patrick, Jr. Olivia Poole t. Page 1 and 2 shou...

of Health and Me

" 27 is m." 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara A. Patrick (Spouse) 2170 Daisy Road, Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Donation 5 Other (Specify) Oak Grove Cemetery 5/2/2011 Glenwood, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service Licenses once Haucht 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Endstage disease or condition Medical resulting in death) Examiner Securations list remains a frank, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day 2 No signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? or Attending Physician: The law certificate has autopsy page 2 performed? Yes 2 No 2 No I ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No ည 1 Inpatient 2 FR/Outpatient 3 I DOA 4 ☐ Nursing Home 5 → Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred : After (Month, Day, Year) Natural injury 5 Pending 1 ☐ Yes 2 🗹 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed/(Month, Day, Year) Maruman H0562176 Md 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Show Tammana PC Swarna 31. Date filed (Month, Day, Year, Signature State Registrar

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			1 - State Registrar		,	-		te of L				Reg. No	00	E E	138	20	
I	Physici /Medic		Decedent's Name (First, Middle, Last) FAYE PURDUM		2. Date of De APRIL 2						ath 3. Time of Death 7, Day 2011 10:45 A M			Death A M			
	Examin		4a. Facility Name (If not institution, give stre				Location of	of Death			4c. County of Death						
	Funeral Director		4303 WHITE AVE 5. Social Security Number 6. Sex 1 - Number 6. Sex	last birthday) Yrs.		CIMOR er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bit (Month, Da JULY 2:		N/A 9. Birthplace (State or Foreigr Country) 1922 WEST VIRGINIA			-			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				,			1	0d. Inside City	y Limits	
5-0036 72 hours after death with the Maryland	Maryla -f sho	ţo	MD N/A			TIMORI								1 ∏ Yes	,		
	or 28s	Director	10e. Street and Number		DILL	11 IIIOK	10f. Z	ip Code					0g. Citizen of What Country?				
	s 23a	Funeral	4303 WHITE AVE	. Was Decedent E	vor in 11	S 12		.206	ionania Ori	idin? /Sno	nifu Voo or No	US.		Amaria	an Indian,		
5-0036	d within 72 hours after death with the Marylan glene. r than "natural", or items 23a or 28a-f show the Madical Examinat must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								, White, e			
Maryland 2121	ithin 72 ho ne. nan "natur Medical i	Completed by	15. Decedent's Educat (Specify only highest grade of	ion <i>ompleted)</i> College (1-4or 5-	+)	(Give	. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ORE MANAGER						16b. Kind of Business/Industry				
	othe rent,	Be	17. Father's Name (First, Middle, Last) JAMES ELLER		I					18. Mother's Name (First, Middle, Ma UNKNOWN				aiden Surname)			
	12 sho	P.	19a. Informant's Name/Relationship (Type JAMES MAXWELL-SON	. Print)				dress (Street and Number or Rural Route Number, City or Town, Sta THITE AVE BALTIMORE, MD 21206					State, Zip	Code)			
Baltimore,	ë = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	C	Place of Dispo emetery, crei	natory or OF FA	other plac AITH		4/30/		BAL	ocation - TIMO	RE, N	Œ		
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee			64	15 B	ELAI	R RD	BALT	IMORE,	, MD			HOME,		
1	Physician /Medical Examiner		23a. P Enter the disease, or complicate shock, or hear if the LV to only one immediate Cause (Final disease or condition resulting in death)	Due to (or as a	3 D	10 -	PU	LM (g, such as	RY	A	RR	ES	T	Approximate Interval Betw Onset and D	/een /eath	
68760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a	uence of):												
.O. Box 6	w requires that the death certificate be executed to be executed to be en signed by the attending physician and should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					23d. Date of delivery Month Day Yea			'e ar				
ecords, P	quires that en signed t uld be deta	þ	Part II. Other significant conditions contri	buting to death bu	not resu	ulting in the u	nderlying	cause give	en in Part I		100	3e. Did tobacco use contribute to the cause of death? 1 ➤ Yes 2 □ No 3 □ Probably 4 □ Unknown					
ပ္ပ	2 3 8	Completed									auto perfi 1 □ Yes	a. Was an autopsy performed? performed? 24b. Were autopsy findings available prior to completion of cause of death? 1					
>	rsiciar s certif	o Be	25. Was case referred to medical examiner?	pital:	nt 2 🗆	ER/Outpatie		Othe	or.	of Death ursing Hom	(Check only		6 □Othe	r /Spacie			
VISION OF	nding Phy tth. r: After this e funeral c	ation: To		28a. Date of Injui (Month, Day		28b. Time o Injury		28c. Injur		2	8d. Describe				y/		
DIVIS	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: T	3 Suicide 6 Could not be 4 Homicide determined	ry - At ho . (Specif	t home, farm, street, factory, office 28f, Local						cation (Street and Number or Rural Route Number, ty or Town, State)						
	the Hospi nin 24 hou the Funer npletely fill	Medical	29a. Certifier Certifying Physic (Check only one)	ian: To the best of r: On the basis of and manner sta	examina	wledge, deat tion and/or in	vestigation	on, in my o	pinion, dea	nd place, a ath occurre	and due to the	, date ar	nd place, a	and due to	the cause(s))	
)	To with	2	29b. Signature and this of certifier	arof	1/27	A		9c. Licenso	number 2	156	29	29d. D.	ale signed	(Month,	Day, Year)		
			30. Name and address of person who com	oleted cause of de	eath (Item	1 23a) (Type,	Print)	Av	2. 10	PINE	on. I	ID	21	280	0		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) APR 2 9 201	32. Registra	ar's Signa		arke						_				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam Purdue 1- For State Registrar	State of Maryla		ent of Hea ate of Dea		ntal Hygiene	Reg. N		1 1382		
Physician/ 1. Decedent's Name		,			2. Date of Month	Day	y Year	3. Time of Death 1050 hrs		
WILLIIII	M. M. PERDUE, JI not institution, give street and nu		4b. City	Town, or Location		26, 2011	4c. County of De			
Mercy Hospi				more			N/A			
Funeral 5. Social Security No Director 231_02_8		7. Age (In yrs. last birt	nday) If Un Mon		1 340-	,	1Fo	Birthplace (State or reign		
Usual Residence of		46	Yrs.		NOV	/. 14,	1964	Country) VIRGINIA		
. 1	10b. County	10c. City, Town	or Location					10d. Inside City Limits		
MD. 10e. Street and Num	N/A	BALTI	MORE					1 X Yes 2 No		
the Maryland 10e of 28-1 should be maryland 10e of 28-1 should be street and Num 10e of 10e o	nber		10f. Z	p Code		10g. C	itizen of What C	ountry?		
et 103 E. M	MOUNT ROYAL AVE	APT. 501		21202	:		TED STA			
Tunition of the state of the st	d 2 Married Armed Fo				rigin? (Specify Yes n, Puerto Rican, et		No- 14. Race - American Indian, Black, White, etc.			
by FL by FL	4 Divorced If Yes, Give Yee		1 Yes	2X No specify	y :		Specify:	WHITE		
15. Decedent's Edu	ucation (Specify only highest grad			Occupation (Give orking life. DO NO	kind of work done Tuse retired)	16b	. Kind of Busine	ss/Industry		
Hin 72 Page 1 12TH		-4 or 5+)	VICIIAI	DESIGN			CLOTHIE	D		
Pededent's Ed. 15. Decedent's Ed. 16. Decedent's Ed. 17. Father's Name (F. 17. Father's Name (F.)			VISUAL		er's Name (First, Mi	ddle, Maide		K		
Mental Hygiene. To Mental	M. PERDUE, SR.			1	TTY CORRE					
ADD 19a. Informant's Nan ADD 19a. Informant's Nan MILLIAM MILLIAM MILLIAM	me/Relationship (Type, Print) M. PERDUE, SR.,	0.4	_	,	mber or Rural Rout	,		• •		
Paritimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Influence 1 filem 27 is marked other than "natural", or items 23 a or 23s-1 should be filed within 72 hours after death with the Maryland 10 Second 1 filem 27 is marked other than "natural", or items 23s or 23s-1 should be confered than "natural", or items 23s or 23s-1 should be confered to the Maryland 12 Decedent, and 12 Director 13 Decedent, and 14 Decedent, and 15 Director 14 Double 1 Director 15 Decedent, and 16 Director 16 Double 1 Director 17 Double 1 Director 18 Double 1 Director 19 Double 1 Director 19 Double 1 Director 10 Double 1 Director 10 Double 1 Director 10 Double 1 Director 11 Director 12 Director 13 Director 14 Double 1 Director 15 Director 16 Director 17 Director 18 Director 19 Double 1 Director 19 Double 1 Director 10 Director 11 Director 12 Director 12 Director 13 Director 14 Director 15 Director 16 Director 16 Director 17 Director 18 Director 19 Director 10 Director 10 Director 10 Director 10 Director 10 Director 10 Director 11 Director 12 Director 13 Director 14 Director 15 Director 16 Director 16 Director 17 Director 18 Director 18 Director 19 Director 10 Direct	osition	20b. Place o	f Disposition (Na	ame of cemetery,	Date		Location - City			
To be a superior of the control of t	Cremation 3 Removal fro		ory or other place IC CREM	•	4/28/20	11 61	FN BURN	IE, MARYLAND		
21. Signature of Fun	eral Service Licensee	11111111						SON, INC.		
ALVEN A					VE., BALT					
Physician //Medical 23a, Part I. Enter the failure. List only	e disease, or complications that ca or one cause on each line.			of dying, such as	cardiac or respirato	ry arrest, s	hock, or heart	Approximate Interval Between Onset and Death		
Immediate Cause (Fi or condition resulting		nary Artery Thron consequence of):	nbosis					Death		
Sequentially list cond	ditions,	otic Cardiovascul	ar Disease							
if any, leading to firm cause. Enter Underl	lying Cause	consequence of);								
events resulting in de	eath) Last Due to (or as a	consequence of):								
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IF FEMALE: 23b. Was decedent pr	seement in the	outcome of pregnancy		- 🗆	. 1000	2	3d. Date of deliv	-		
the death certificate death certificate the death certificate death certificate that the death certifi	LIVED	rth 2 ant at time of death 5	Fetal death Other (Sp		ic pregnancy	- 1	Month	Day Year		
Y Yes 2 No	9 011813									
Division of Vital Records, P.O. Box 6876. To the Hoopital or Attending Physiciae: The law requires that the death certificate within 24 hours after death. To the Fueral Director: After this certificate has been signed by the attending phy to functal dilled in the attending phy to functal	cant conditions contributing to	death but not resulting	in the underlyin	g cause given in P	_			to the cause of death? robably 4 Unknown		
rds, requires been signed be leted						Was an		autopsy findings available		
Division of Vital Records, tal or Attending Physiciae. The law require as after death. and Director, page 2 should be better a					_ _	autopsy performed?	death			
Be Cortificate certificate case referre examiner?	ed to medical			26.Place of Death	(Check only one)	Yes 2	No 1 🗸	Yes 2 No		
examiner?	No Hospital: 1	npatient 2 🗹 ER/Ou	tpatient 3	OOA Other	Nursing Home	5 Resid	dence 6 Ot	her:		
27. Manner of Death		of Injury 28b. T Day,Year)	ime of Injury	28c. Injury at Wor	_	cribe how in	njury occurred			
Accident 2 Accident 2 Accident	5 Pending Investigation	of Injury - At home, far	m street feeter	1 Yes 2		tion (Ptropt	and Atumber or	Rural Route Number, City		
Division O	6 Could not be determined (Specify)	or injury - At nome, fai	m, street, ractor	y, office building, e		wn, State)	and Number of	Rural Route Number, City		
Division To the Hospital or Attend within 24 hours after death within 24 hours after death 170 the Fuoral Director: Completely filled in Howing Councile (Check only one) 2 Mm. A coident 3 Mm. Spring Councile (Check only one) 2 Mm.	Certifying Physician: To the bes	of my knowledge, dea	th occurred at th	e time, date and p	ace, and due to the	cause(s) a	ind manner as s	tated.		
of the state of th	Medical Examiner: On the basis of and manner st									
29b. Signature and tit	tle of certifier	1.	29	c. License number O.C.M.E.	•		. Date signed <i>(I</i> i ril 27, 2011	Month, Day, Year)		
- Car	or Hal	ldu		J.O.IVI.E.		Λρ	111 41, 4011			
30 Name and address	ss of person who completed cours	e of death (Item 23a)								
30. Name and address Carol Allan, N	ss of person who completed caus MD Assistant Medical I	•	/. Baltimore	Street, Baltim	ore, MD 21223	3				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wilma Yvonne Parker April 24, 2011 4:57 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fox Chase Nursing & Rehab. Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Hours 577-52-0554 1273071935 Director 75 DC Usual Residence of Deced 28a-f show 10a. State with the Maryland Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Tes 2 No 10e. Street and Number ō 10f. Zip Code 10a. Citizen of What Country? Funeral or items 23a 1923 East West Highway 20910 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Yes 2X No δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2XXNo Specify: "natural", Completed 3 ₺ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 11 Homemaker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evo ၉ Addison Ruddock Powell Emma Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Pamela M. Parker, daughter 1923 East West Highway Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 TCremation 3 Removal from State Chesapeake Crematory | 4/27/2011 4 Donation 5 Other (Specify) Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia- Advanced Physician/ disease or condition 6 mos Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Day Year Pregnant at time of death Yes 2 XXNo 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available 24a. Was an this certificate has autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2XXNo within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 🔀 No Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Zionature and title of certifie 29d. Date signed (Month, Day, Year) DILL D28656 4/26/2011

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month Day, Year APR 29 2011

Ravi Passi MD; 15245 Shady Grove Rd. #130 Rockville, MD 20850

d address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - For Amend Item 25 pt	ate of Magyland	54 7287 Cert	tment of F ificate of C	lealth and N Death	lental Hyو. ا	giene 2	011	13823				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death				
×	Medic Examin		Brenda Ross 4a. Facility Name (if not institution, give street a		Location of Death			nty of Death	WZBPM						
شري .	<i>!</i>		5. Social Security Number 6. Sex	- Shock Tran		Balk m	If Under 24 Hrs.	Lo Data (Did		Baltimore City					
	Funeral Director		233-94-7485 1 M 2	7. Age (In yrs. last		Months Days	Hours Min.	8. Date of Birt (Month, Day	17, 1947	Gount	olace (State or Foreign try) Ohio				
	ind show at	o	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	ation				1	0d. Inside City Limits				
	Maryla 28a-f otified	Director	MD Anne Arur	ndel			Pasadena	l			1 Yes 2 □ No				
	n with the ns 23a or nust be r	Funeral D	10e. Street and Number 8255 Camion Ct.			10f. Zip Code	21122		10g. Citizen o	U.S.	*				
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampirity or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 If N	as Decedent Ever in U.S. med Forces? Yes 2 ANo res, Give ar or Dates.	as Decedent of His Yes, specify Cubar	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	В	14. Race - American Indian, Black, White, etc.						
15-(72 hou n "nath Aedica	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	(Give ki	ent's Usual Occupa nd of work done d NOT use retired)	ation Juring most of work	ing	16b. Kind of	16b. Kind of Business Industry					
212	within ygiene.		104h	llege (1-4 or 5+)	<i></i>	School	Bus Driver	us Driver Public School							
and	be filed ental H rked otl ic even	To Be	17. Father's Name (First, Middle, Last)	obert Tyrell			18. Mother's Nam		Maiden Surna J de Vivia		es				
, Mary	d 2 should aith and M 27 is ma er traumai		19a. Informant's Name/Relationship (Type, Prin Michael A. Ross spo	ouse		o. Mailing Address (Street and Number or Rural Ro 8255 Camion Ct. Pasadena, MI									
altimore, Maryland 21215-0036	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)		netery, crema	ition (Name of atory or other place n Cemetery	e) i	Date 19, 2011		- City or Town, State . Clairsville, Ohio					
Balt	permit. Depart Import any inj once,		21. Signature of Funeral service Licensee	at Morza	3 22.	Name and Addres Slack Ft 3871 Ok	s of Facility uneral Home, d Columbia P	P.A. ike Ellicott (ity, MD 2	1043					
٠,	mysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition a. Brown even of the mode of dying, such as cardiac or respiratory arrest, shock or learning the shock of the mode of dying, such as cardiac or respiratory arrest, shock or learning the shock of the mode of dying, such as cardiac or respiratory arrest, shock or learning the shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, such as cardiac or respiratory arrest, shock or learning the mode of dying, shock or learning the mode of dying the mode of d												
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09/	ate be physicia the bu	edical	d				CERTIFICATION AP	APPROVED BY MEDICAL EXAMINER							
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		in the past 12 months?	res, outcome of pregnand ☐ Live Birth 2 ☐ Fetal o ☐ Pregnant at time of dea ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delivery Month Day Yea						
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Division of Vital Records, P.O.	ne law require: e has been sig age 2 should b	Completed						24a. Was a autop perfo	rmed?		osy findings available mpletion of cause of				
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Ž.	ding Physician: The le h. After this certificate ha funeral director, page	၉	1 X Yes Z No	1 Inpatient 2 El	R/Outpatient 8b. Time of	3 DOA Othe	4 ☐ Nursing Ho	ome 5 Resid)				
on o	ending eath. or: After he fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury 	work'	? Yes 2 □ No	204. 00001100 11							
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	e Hospi e Funer e Funer	Medical	29a. Certifier 1 Certifying Physician: 1 Certifying Physician: 1	the basis of examination a	and/or investig	gation, in my opinio	n, death occurred a	t the time, date a	nd place, and	due to the cau	use(s) and manner stated.				
_	To th Withir To th	2	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, L	Day, Year)				
			30. Name and address of person who complete		3a) (Type, Pri	Nel 4	427218	1012	4/ rist1	14/20	11				
			22 South Gree	ne st B	a Homo	ne Hary	land	K	risti	c Bu:	SUL				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3.51 PM 2. Date of Death 4Menth Physician/ Adriana de los Angeles Ramirez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia. Country) Cuba **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. 07/09/1932 78 Director 148-36**-**6570 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at death with the Maryland Director MD Anne Arundel Millersville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8535 Suite 315 21108 U.S.A. Veterans Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian. 11. Marital Status Armed Forces? Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 XXVes 2 □ No Specify: Specify: Cuban Completed 3 Widowed 4 Divorced Hispanic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nould be filed within 72 Ind Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home 5+ Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ဂ Adriana de los Angeles Ramirez Miguel Angel Garces 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 Legartment of Heath an Important: If item 27 is n any injury or other husband MD8535 Veterans Hwy Ste. 315 Millersville, Mr. Jorge B. Ramirez, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 04/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 1 2nd Ave, SW Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Terval Between Immediate Cause (Final emorrha Vaceve Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securetially flat conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ P.O. Box in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death n signed by the a Id be detached fo 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: 1 Inpatient ပ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No s after death. Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Fractioner: To the best of try knowled 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 41365 VIVE uta 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeova 31. Date filed (Month, Day, Year) Registrar's Signa State 8 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charlotte Robinson	State of Maryland / Department of Health and Mental H 1- For State Certificate of Death	lygiene 2011 13825					
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death					
Medical Examiner	CHARLOTTE M. ROBINSON	April 25, 2011 0036 IIIS					
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3906 Penhurst Avenue Apt. A Baltimore	h 4c. County of Death					
		s. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign					
Funeral Director	Months Dave Hours Mir	Country)					
Biredior	2] 6 - 4 2 - 7 6 6 5 1 M 2 X F 6 8 Yrs. World Says Totals Will Usual Residence of Decedent	04-03-]943 MD					
any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits					
*	MD BALTIMO	1_ Yes 2 No					
with the Maryland s 23a or 28a-f show a e notified at once.	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?					
a or 2 tiffed	3906 PENHURST AVE APT A 21215	II.S.A.					
with ms 23 be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- 14. Race - American Indian, Black,					
r death with or items 23 must be no	1 Yes 2 YNo	Wille, etc.					
s after rral"; niner	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	Specify: BLACK work done 16b. Kind of Business/Industry					
hour "natu	Elementary/Secondary (0-12) College (1-4 or 5+)						
0036 within 72 hour by than "natu by the "hatu c Medical Exar]] th COOK	FOOD SERVICE					
5-0036 led within 7 Hygiene. other than the Medica	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maiden Surname)					
218 be fill mtal H rrked ent, t		NCE PAYNE					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)					
MD and 2 sho allth and 2 m 27 is raumati	RENEE A PHILLIPS - NIECE 722 N CAPROLLTO 20a. Method of Disposition (Name of cemetery,	NAVE BALTO NE 2]2] Date [20c. Location - City or Town, State					
Baltimore, permit. Pages I an Department of He Important: If ite	1 Burial 2 Cremation 3 Removal from State crematory or other place)						
t. Pag tment tment rtant:		-29-20]] Balto, MD					
Balti permit. Depart Import injury		illiam Brown Comm. F/H					
Physician	Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval					
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	Between Onset and Death					
Examiner	or condition resulting in death) Due to (or as a consequence of):						
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
mine mine	Co						
ted Insit Examiner	events resulting in death) Last Due to (or as a consequence of):						
0, be executed risician and burial - transit	UNPENDED AMENDED						
Box 68760 he death certificate by the attending physical performance of the for use as the burthsical physical	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery nancy Month Day Year					
certife ending use as cian	230. Was decedent pregnant in the past 12 months?	in the state of th					
Box te death of the atten red for us	1 Yes 2 V No 9 Unknown 9 Unknown						
O. Bo at the de de by the creached for Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?					
s, P.O. irres that the signed by a libe detached by a libe detached by PP	Diabetes mellitus, Chronic Obstructive Lung Disease	1 Yes 2 No 3 Probably 4 Unknown					
of Vital Records, in Physician: The law requirer the this certificate has been significate in To Be Completed		24a. Was an autopsy findings available prior to completion of cause of					
Recc The lar cate ha		performed? 1 Yes 2 No 1 Yes 2 No					
Vital Recysician: The his certificate director, page	25. Was case referred to medical 26.Place of Death (Check examiner?						
F Vit	1 Yes 2 No No Inpatient 2 ER/Outpatient 3 DOA Nursi	ing Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred					
n of V ding Ph. After tl	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	250. Describe now injury occurred					
ivisior I or Attend after death. Director: d in by the	2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc.	28f. Location (Street and Number or Rural Route Number, City					
Division o pital or Attending ours after death. reral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State)					
C Tr D D D D D D D D D	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cause(s) and manner as stated.					
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date and place, and due to the cause(s)					
E * F 8	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)					
	Carde Hellan O.C.M.E.	April 25, 2011					
λ	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, M.	MD 21223					
State	31 Date filed (Month Day Vear) 32 Reportar's Streature						
Registrar	APR 29 201 Deven S. Salls						

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 04-22-201 Pay Physician/ 700 P Mary R. Ryan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air 736 Danville Circle 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 04-07-1936 Country) Months Days Hours Min 1 □ M 2 🗓 F 75 Director 212-34-6491 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2X No Bel Air Harford MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21014 736 Danville Circle Id be filed within 72 hours after death v Mental Hygiene. arked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Ves 2 No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the Homemaker house wife Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mae Schaffer should be fi and Menta John Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 736 Danville Circle Bel Air, MD 21014 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Charles L. Ryan Jr. (Husband) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) Bunal 2 ☐ Cremation 3 ☐ Removal from State 4-27-2011 Baltimore, MD 5 Other (Specify) Lorraine Park 4 Donati 22. Name and Address of Facility Schimunek Funeral Home of BelAir Funeral Service Sicense 21. Signature Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav P.0. signed by t. d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 N To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2No 1 Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury 28c. Injury at Natural Certificate: (Month, Day, Year) injury work?
1 Yes 2 No 5 Pending Investigation Accident 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Decrtifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Month, Day 29b. Signature and time of certifier 32. Registrary Signat State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April ^{Day} 2011 4:40 P M 25 Mildred Ophelia Rilev Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 111 Sunshine Court Unit L Forest Hill 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, 1 □ M 2 🛭 F Days Hours Min Tllinois Months 220-03-3055 **Director** 90 920 Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛮 No Forest Hill Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 111 Sunshine Ct. Unit L 21050 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Laura Bell Waddel Clyde Vernon Tibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Riley / Daughter 111 Sunshine Ct., Unit L, Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Air Memorial Gdn. 4-28-11 Bel Air, Maryland Signature Funeral Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician disease or condition Medical resulting in death) Due to (or as consequence of): Examiner 14 MEAN Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has be manufaited filled in by the funeral director, page 2 s autopsy performed 2 🗌 No 1 Tyes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Tes 2 🗖 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR

29

Registrar's Signatu

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year **Physician** Bankera Rasmeke 24, 2011 Silen April 4:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 1405 Alexis Drive Harford Joppa If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 □ XF 226-24-1139 89 Virginia Director Feb. 1922 Usual Residence of Decedent permit. Peges 1 end 2 should be filled within 72 hours efter death with the Marylend Department of Health end Mental Hygiene. Important: If them 27 is marked other than "natural; or flows 23a or 23a-f show any injury or other traumetic event, the Medical Exercions. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts 1 ☐ Yes 2 ☐ Mo Directo Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1405 Alexis Drive 21085 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑No Specify: Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 11 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie (unk) Powers David Henry Tiller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1401 Alexis Drive, Joppa, Maryland 21085 Emma E. Allen / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Memorial Gdn 4-27-11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) CAD Years Examiner Due to (or as a consequence of): Physician/Medical Examiner ettending physician en-for use es the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 3 Probably 4 Unknown signed by 1 Yes 2 No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 XNo 1 ☐ Yes 2 ☐ No demanded 1 Yes within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospitai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 3/295 4/25/11 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulhnore 212060 Wend Kloes 2 5701 mo Kenuscock 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia	ın/	1. Decedent's Name		e, Last) .e Rosema	n			, timou	10 01 2	- Catin		2. Date of D		100	Year	3. Time of 1:05	Death
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Page 1 a ment of H tant: If ite ury or oth		20a. Method of Disp 1 🔀 Burial 2 4 🗌 Donation	☐ Cremation	3 Removal fro	m State	20b. F	Place of Disp complete.com emete:	srae.	$\Gamma^{therplace}$	1	•	Ž ^{ate} 2011	Has	tings	On H	Town, State udson,	
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Physician/ Medical		Immediate Cause (disease or conditio resulting in death)		a		neum										Onset and D	eath
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicit completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		/e Birth egnant a		al death 3	☐ Ectopic ☐ Other (s		у					ate of deli	-	ear
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r Physier this ceral dire	e: To	1 Yes 2 2 27. Manner of Death	No n	28a. Da	te of inju	ry	ER/Outpation 28b. Time		28c. Injury	4 ⊔ N at	ursing H	ome 5 Res		6 ℃ Otl	ner (Speci	fy)	
tending eath. or: Afte the fund	Certificate:	1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide	5 Pendir Investi 6 Could	gation	onth, Day	y, Year)	injury	М	work?	? Yes 2] No						
ital or Att Irs after d ral Direct led in by t		4 Homicide	determ	nined 28e. Pla bui	ding, etc	C. (Specify						City or To	wn, Sta	te)		al Route Numbe	er,
e Hosp 124 hor e Fune	Medical	(Check 2	Medical E	Physician: To the xaminer: On the b Nurse Practions	asis of e	xaminatio	n and/or inve	stigation, in	n my opinio	n, death o	ccurred a	t the time, date	and pla	ce, and di	ue to the c	ause(s) and mar	ner stated.
To th within Comp		29b. Signature and				~77	,	29	c. License	number	1		29d. [Date signe		, Day, Year)	
		30. Name and addre	ess of person	who completed ca	use of d	eath (Item	n 23a) (Type,	Print)			о м	onvil on A	_		J, 21		
و √ Stat	e <	Ava Kauf APR 2 9		D. 821				enue	, bet	nesda	a, II	aryland	. 20	014			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ APRIL 25 201 Par 4:21 ALBERT ROSSI рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE MANORCARE ROSSVILLE BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Months SEPT Day, 1 XM 2 - F Min 6,1920 MARYLAND 171-14-1207 **Director** 90 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral SELFRIDGE 21205 U.S.A. 5312 AVENUE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Divorced Completed Year or Dates 943-46 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 FOREMAN STATE OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked o မ MATTHEW ROSSI N/A19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5312 SELFRIDGE AVENUE, BALTIMORE, MD 21205 ESTHER ROSSI/WIFE permit. Page 1 and 2 Department of Health Important: If item 23 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State BAYVIEW CREMATORY 4/26/11 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee June and Address of Facility (ILLY & ZEILER INC. FUNERAL HOME 901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dementia Physician/ End disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been executed. been signed by the attending physician and should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? eart 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been funeral director, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 LNo Yes 2 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: ျှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, 69540 M.D 201) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swite 204 Parkville 31. Date filed (Month, Day, Year) State 29 2011 Registrar

DHMH 17 Rev 7/2009

Please Type of State

or Print in Black Indelible Ink. Ensure All Copies Are Legible of Maryland / Department of Health and Mental Hygiene	20	1	7	1	2	0	-
e of Maryland / Department of Health and Mental Hygiene	20	2	e e	ž.	3	O	1

Daniel Nathan Ro		rtson 1- For State Registrar	State	of Maryla		artment o		nd Menta	l Hygiene	Reg. No	201	
Physiciar	1/	1. Decedent's Nam		,					2. Date of I	Death Day	Year	3. Time of Death
Medical Examin		Danie 4a. Facility Name (i	el Nath				4b. City, Town,	or Logotion of C	April 26	, 2011	c. County of De	0538 hrs
		,	Regional Med		nber)		Salisbury	or Location or I	Jean		Wicomico	eau i
Funeral		5. Social Security N		Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye		24Hrs. 8. Date of	Birth(MM	/DD/YYYY) g.	Birthplace (State or
Director		213-97-	-5404	X M 2∏F	35	Yrs	Months Da	ays Hours	Min. Jan	23	,1976 ^{F°}	Country) MD
*up	F	Usual Residence of 10a. State	f Decedent 10b. County		Inc. City	Town or Locat	ion					10d. Inside City Limits
		MD	Carro	11	livo. Only,	701117-01-20001		inste:	r			1 X Yes 2 No
arylan 8a-f sl	Director	10e. Street and Nu					10f. Zip Code			10g. Cit	izen of What C	ountry?
- 25		301 E.	Main S	t.,Apt	. 13			21157		Ţ	JSA	
th with	Funeral	11. Marital Status 1 Never Marrie	ad 2 Marria		edent Ever in U.				? (Specify Yes or uerto Rican, etc.)	No-	14. Race - An White, etc	nerican Indian, Black,
er dear		3 Widowed		1 Yes	2 X No	1	Yes 2X N				Specify: Wh	ite
urs aft		15. Decedent's Ed		or Dates:			nt's Usual Occup	ation (Give kin		16b.	Kind of Busine	
6 72 ho	Сотріете	Elementary/Seco	ondary (0-12)	College (1-	-4 or 5+)		ost of working li structi				onstru	ation
5-0036 iled within 7. Hygiene.	틹.	1.2	(First Middle Look			Cons			Name (First, Midd			
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21 ould b d Men is mar		19a. Informant's Na						eet and Numbe	r or Rural Route I	Number, C	ity or Town, St	ate, Zip Code)
MD and 2 sho alth and 27 is raumati	1	Deboral 20a. Method of Disp	n L. Ma	rlin-mo			E. Mai		,Westmi			21157 or Town, State
Ore,	1	1 Burial 2		Removal fro	m State	crematory or ot			4-28-11			ster, MD
Baltimore, permit. Pages I a Department of He Important: If ite	1	4 Donation 5 21. Sign ture of Fu			We				Fletche			·
Ba perm Depa injur	Ţ	hom	1	7 like	w_ 111				t.,West			
Physician	1	23a, art I. Enter th	e disease, or com		used the death.							Approximate Interval Between Onset and
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	-	or condition resulting	, h	Due to (or as a	consequence of	f):						
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scuted and transit			d									
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Box 68760 he death certificate by the attending physished for use as the butter of the	2	IF FEMALE: 3b. Was decedent		23c. If yes, o	utcome of pregr rth		tal death 3	Ectopic pr	regnancy	23	d. Date of deliver Month	ery Day Year
Box 6 e death cer the attendi		past 12 months			ant at time of dea	ath 5 Ot	her (Specify)					
b. Bc the de ched for the a	≥L	Part II. Other signif		9 Unknow		esulting in the u	inderlying cause	given in Part I	23e. Di	d tobacco	use contribute	to the cause of death?
ords, P.O. I we requires that the as been signed by the should be detached by the property of	5			v						Yes 2	No 3 P	robably 4 🗹 Unknown
rds, requir	<u> </u>								24a. W	as an topsy		autopsy findings available to completion of cause of
Records, The law require, ficate has been sig, page 2 should be						_			pe	formed?	death	?
# 8 E 5 C	ו פ	25. Was case referr					26.Pla	ce of Death (Ch	neck only one)			
F Vitz Physicia or this ce	2 L	1 Yes	2 No			ER/Outpatient			ursing Home 5			her:
Sion of Attending Pl r death. rector: After by the funeral	<u> </u>	27. Manner of Death 1 Natural	5 Pending		Day,Year)	28b. Time of I		jury at Work? Yes 2 🕱 No	subie	ct ii	ury occurred ngested	drug and
ivisior I or Attend after death. Director:	<u> </u>	2 Accident 3 X Suicide	Investigat 6 Could not	28e Place	of Injury - At ho	fd 5:12 ome, farm, stree		building, etc.			and Number or	Rural Route Number, City
Divisior Bospital or Attend 24 hours after death Funcral Director: stely filled in by the	ĘĹ	4 Homicide	determine		Found 0	utside			Salis	bury	Md. Eas	Rural Route Number, City t Main St.
To the Host within 24 host completely u	<u> </u>		Certifying Physic Medical Examine									
To the Ho within 24 To the Fu completely		29b. Signature and		and manner sta	ated.	Toron mrooning an		nse number				Month, Day, Year)
		61	1 ,	, ,	19	1	0.0	.M.E.		Apr	il 27, 2011	
	1	30. Name and addre	ess of person who	completed cause	e of death (liem	23a)						
2		Zabiullah Ali					Saltimore Str	eet, Baltimo	ore, MD 2122	3	-	
Stat Registra	~	31. Date filed (Monti	h, Day,¥ear) . K∏∏ ¶ Q o	32. Reg	gi par's Signatu	re						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 13832 State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	5 to 15 to 1	Certific	ate of Death		Reg	. No.	
Physician/	1. Decedent's Name (Fir	st, Middle,Last)				Date of Death Month	Day Year	3. Time of Death
Medical Examine	JUDAII	institution, give street and no	RINGER	Ab City Town	or Location of Death	April 25, 20	11 4c. County of Deat	
		dventist Hospital	inder)	Rockville	of Education of Boats		Montgomery	
Funeral	5. Social Security Number						(MM/DD/YYYY) 9. Bi Forei	
Director	213-87-917	73 1XM 2_F	1	Yrs. Months Da	ys Hours Min	12/19/	2009	ountry) MD
ń	Usual Residence of Dec	edent County	10c. City, Town	or Location				10d. Inside City Limits
ii C. C.	100	FREDERICK		ERICK				1 Yes 2 No
the Maryland or 28a-f show tified at once. Director	10e. Street and Number	FREDERICK	FRED	10f. Zip Code		100	. Citizen of What Cou	intry?
the Maritified Dire	502 ELLIS	SON COURT		21	703		USA	
er death with the Maryland , or items 23a or 28a-f sho rmust be notified at once. Funeral Director	11. Marital Status	12. Was De	cedent Ever in U.S.	13. Was Decedent of H			14. Race - Amer White, etc.	ican Indian, Black,
or ite	1 XXNever Married	1 Yes	2 XX No			rticall, ctc.,		HITE
rs affe		Divorced If Yes, Give Yes or Dates: on (Specify only highest gra		1 Yes 2 X N Decedent's Usual Occup	o specify: ation (Give kind of	work done	Specify: W 16b. Kind of Business	
11215-0036 Id be filed within 72 hours after fental Hygiene. sarked other than "natural", event, the Medical Examiner D Be Completed by	Elementary/Secondar			during most of working life	e. DO NOT use ret	ired)		
5-0036 ed within 7. tygiene. other than the Medical	0			NONE			NONE	
filed v Hygi at other controls of Co						(First, Middle, Ma		
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than its event, the Medical TO Be Comple			RINGER 19	b. Mailing Address (Stre	MARQUI eet and Number or			LAKESLEE e, Zip Code)
MD d 2 shot lith and lith and m 27 is 1 mumatic		NGER/FATHER		502 ELLIS	ON COURT,	FREDERI	CK, MD 21	703
	20a. Method of Dispositi			of Disposition (Name of c			20c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite	4 Donation 5	Other Specify:		MOSES CEME	TERY 04/	28/2011	PINELAWN	, NY
Salti ermit. Separtr mport njury	21. Signature of Funeral	11 1//		22. Name and Addre	, 9		SON & BROS	
Physician	2 a. Part I. Enter the dis-	ease, or complications that of		1 8900 REIS	STERSTOWN a. such es cardiac o	ROAD, P	IKESVILLE, t, shock, or heart	MD 21208 Approximate Interval
/Medical	failure. List only on	e cause on each line.		Meningitis				Between Onset and Death
Examiner	Immediate Cause (Final or condition resulting in		consequence of):	Henringreis				
	Sequentially list condition							
mine mine	if any, leading to immedi cause. Enter Underlying (Disease or injury that in	Cause c.	consequence of):					
ted Insit Examine	events resulting in death) Last Due to (or as a	consequence of):					
760, cate be executed physician and the buriat - transii		d AMENDED	23a,27 pe	er me g915 5	-6-11 vt			1
760, cate be execu physician and the burial - tr	IF FEMALE:		outcome of pregnancy				23d, Date of deliver	у
ox 687 sath certific attending p or use as th		, Cliver			Ectopic pregna	ancy	Month	Day Year
D. Box 687 the death certification by the attending sched for use as the physician.	1 Yes 2 No 9			5 Other (Specify)				
ital Records, P.O. Box 68 ician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as Be Completed by Physician	Part II. Other significan	t conditions contributing to	death but not resulting	g in the underlying cause	given in Part I.		acco use contribute to	
ires that signed is be deta								bably 4 Unknown
Records, P.(The law requires that ficate has been signed page 2 should be dete		<u> </u>				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Recorder the late of the late						perform 1 ✓ Yes 2		es 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	25. Was case referred to examiner?				Other Nursin		esidence 6 Othe	-
of Vi Physi eral dir	1 Yes 2 2 27. Manner of Death	No 28a. Date (Month	Inpatient 2 ✓ ER/0 of Injury 28b.		ury at Work?		w injury occurred	r.
on of anding Plut. The function of the functin of the function of the function of the function of the function	1 X Natural 5	Pending	ı, Day,Year)		Yes 2 No			
ivisio	2 Accident 3 Suicide 6	Investigation 28e. Place	e of Injury - At home, f	arm, street, factory, office	building, etc.	28f. Location (Str or Town, Sta		ural Route Number, City
Division of 's spiral or Attending Phours after death. neral Director: After tilled in by the funeral Certification: T	4 Homicide	determined (Specify)				Of TOWN, Old	16)	
	Correct orny	fying Physician: To the besical Examiner:On the basis						
To the He within 24 To the For Completel	29b. Signature and title of	and manner s			nse number		29d. Date signed (Mo	
	6.6	1111	1/1	0.0	.M.E.		April 26, 2011	
75V	30. Name and address o	f person who completed cau			- C		7	
	Zabiullah Ali, M.			00 W. Baltimore Str	eet, Baltimore	MD 21223		
State Registrar	31. Date filed (Month, Da	2 9 2011 32. R	gist ar's Signature .	Land				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per me,g914,04/29/2011dhb
Registrar Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07 AM Virgie Ophelia Smoot 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMOIR SAINT AGNES HOSA+A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) **Funeral** 6. Sex Birthplace (State or Foreign Country) Days Hours Min. 1 🗆 M 2 🛣 213-20-8213 Director Yrs. MD 89 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗶 Yes 2 🗌 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21229 U.S.A. 124 Edgewood Street 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 XNo Specify: Black Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' 11th grade College (1-4 or 5+) House Homemaker na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Curtis Walter Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212286107 Chanceford Road Catonsville, Md Virgie Baskerville-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 5/3/2011 Owings Mills, Md of Auneral Service License March F/H West 4300 Wabash Ave, Baltimore, 21215 3a. Part 1 Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition hematoma Subdura Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? signed by the atte Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy After this certificate 2 1 No Yes 2 NO 1 Yes the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ZENo Other: 1 Inpatient 2 ER/Outpatient 3 I DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury. ☐ Natural 5 Pending s after death. I **Dire**ctor: Aft tall 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6107 Chance to, d Rd Chtoms: Mc 4 Homicide determined home Catonsville, MD 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 27, 2011 D47353 M ess of person wito completed cause of death (Item 23a) (Type, Print) 30. Name and Bathunore, Mary 21229 Jeni will 900 Cat Avenue NO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per me 2914 4-29-11 wt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:30P M 2011 20 Warren Edwin Smith April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balto. Franklin Square Hospital Rosedale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year March 29, 6. Sex 1 M 2 □ F Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Maryland 1936 Director 212-32-5751 75 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 TNo Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21236 9116Kilbride Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Director of Student
Activities 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Balto. County Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Wickman Albert Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 9116 Kilbride Road Nottingham, Md, 21236 Pauline Smith Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, State 20a. Method of Disposition 4-25-2011 Timonium, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Subdura Immediate Cause (Final Priysician/ Hemat disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.

To the Funeral Director: Affer this certificat. has been signed by the attending physician and completed filled in by the funeral director, page 2 sh, and be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 1 2 🗌 No ည 1 Yes 1 Mail Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 📉 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 10 UNKnowNM 04/18/2011 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 9116 AL OF . De : COQ of Perry Hall, Mary and 2123 6 Home-driveus Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Apr: 121, 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PM: litello, MD Hill CT, Lutherville Trimble 31. Date filed (Month) Day Vear) 32. F State APR 29 Registrar

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J. W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 26. ^D2011 4:00 A. M John G. Skruch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Hart Heritage Assisted Living Forest Hill Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Min. oct. 9 1 X M 2 🗆 F 74 1936 216-34-7645 Director Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director Harford 1 Yes 2 No Maryland Forest Hill 10e. Street and Number 10g. Citizen of What Country? Funeral 1915 Rock Spring Road 21050 United States 12. Was Decedent Ever in U.S. Armed Forces? 1955 1 Exes 2 No 1959 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2XXNo Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Eastern Stainless Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John James Skruch Mary Theresa Majchrzak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna O'Brien / Daughter 2806 Bynum Overlook Drive Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aprilate 30, cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 2011 Bel Air, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-BelAir
3 Newport Drive Forest Hill, MD 21050 21. Signature of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one call Immediate Cause (Final Onset and Death Consestive +nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 25. Was case referred to medical ASSISTEM B B 26. Place of Death (Check only one) Hospital CARE 1 Yes 2 40 ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 739889 April 27, 2011 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. MACPHAIL BELAIN MA 31. Date filed (Month, Day, 32. Registrar's

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMONTH Physician/ Year 55AM Charlotte Mary Salamone 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Belair Health and Rehabilitation Center Belair tartoro If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) ay 3,1925 1 □ M 2 💢 Months Days Hours Min. Maryland **Director** 219-20-5637 85 May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2X No Md. Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? E. MacPhail Road 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Silver Top Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Howard Sweeney Leona Heintz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98 Stillmeadow Drive Rose Meushaw DTR Joppa, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗀 Removal from State Bel Air Memorial 5-3-2011 BelAir, Md. 4 ☐ Donation 5 ☐ Other (Specify) Schimunek FuneralHome 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as capillac or respiratory arrest Approximate Interval Between Onset an Leath shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last or as a consequence of) signed by the attending physician Physician/Medical The law requires that the death certificate be 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Day Month Year Unknown 9 Unknown P.0. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performe Director After this certificate Yes 1 Yes Hospital or Attending Physician: Vital 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, ō filled i by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 der th. 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a er or To the Funeral Direct determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signa 29c. License number 2

State Registrar

who completed cause of death (Item 23a) (Type, Print)

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BG ROWIETT

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			For State Registrar		State of M	aryland / Depa <i>Ce</i>	artment of I rtificate of			giene Reg. No:	13837
	Physici /Medic		1. Decedent's Name Kasyo		Domonique	e S	anders		2. Date of Dea	Day Year	3. Time of Death
	Examin		4a. Facility Name (If	11	street and number)			or Location of Deal	th	4c. County of Dea	th
			Sinal F 5. Social Security Null	105 pr 1 6. S	a 1	ge (In yrs. last birthday)	If Under 1 Year	MOFE If Under 24 Hrs	8. 8 Date of Birt	h 9 Bir	thplace (State or Foreign
	Funeral Director		unknown Usual Residence of D	1	☐ M 2 ⊠ F	Yrs.	Months Days	Hours Min 55	(Month, Da	1, 2011 M	aryland
	ylano how	,	10a. State	10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	n the Maryland r 28a-f show mouthed at	Director	MD	Ba1	timore	Pik	esville				1 ☐ Yes 2 🛣 No
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03	2 hours after death with atural", or items 23a or cal Expering, must be	d by	3 Widowed 4	□ Divorced	If Yes, Give Year or Dates:		1∐Yes 2√∏No	Specify:		Specify:	Black
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lan.	Aenta Aenta rked tic ev	To B	Ma	arcus Sa	anders				Jasmin	Rowlett	
Maryland	permit, Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 Is marked other the any injury or other traumatic event, I'm once.		19a. Informant's Nan	ne/Relationship (7	Type. Print)	19b. Maili	ng Address (Street	and Number or P	lural Route Numbe	er, City or Town, State,	Zip Code)
	and 2 fealth m 27			Sanders	Father					le, Marylar	
Baltimore,	ges 1 nt of H if ite		20a. Method of Dispo 1 ☐ Burial 2 🔀		Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other pla	:	Date	20c. Location - City or	
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Ba	permit, Pages 'Department of Important: If Ite any injury or of once.	:))	21. Signature Fun	eral Service Licens	J.Wayne (100	2. Name and Address LINE FUN	Δ.		sterstown R erstown, MD	
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Box	ath ce ttendi or use	an/l	IF FEMALE: 23b. Was decedent p in the past 12 m	regnant i	23c. If yes, outcome 1 ☐ Live birth		☐ Ectopic pregnan	су		23d. Date of de Month	Day Year
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	The l ate ha	Completed								rmed? death?	completion of cause of s 2 □ No
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E O	ding h. After funer	io	1 Natural	5 Pending investigation	28a. Date of Inju (Month, Da	ury 28b. Time o ny, Year) Injury	Wor	ryat rk?]Yes 2∐No	280. Describe r	now injury occurred	
Division	Atten r deat sctor: by the	fica		6 Could not be determined		ury - At home, farm, str c. (Specify)		7,00	28f. Location (S	Street and Number or F	Rural Route Number,
ē	tal or s afte al Dire	Certification: To	4 ☐ Homicide	_	building, et	с. (Ѕреслу)			City or Tow	vn, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	ysician: To the best niner: On the basis of and manner st	of my knowledge, deat of examination and/or in ated.	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
	To th withir To th	Me	29b. Signature and tit	le of certifier			29c. Licens			29d. Date signed (Mon	th, Day, Year)
			ne	ileg	LIMB		RE.	5000		April 1	9, 2011
			30. Name and address	1 - 1	completed cause of c	death (Item 23a) (Type,	Print) Li HOSP	ital	2401 W. Baltin	BEIVED	Ere AVE. L 21215
	Sta Registra		31. Date filed (Month,		32 Registr	n D Sind rar's Signature	ald			,	
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DHMH 17 Rev 1/2001

		•	For State Registrar		State of M	larylan		rtmer tificate			and M		giene Reg. N	2011	13838	ŀ
	Physicia		1. Decedent's Name (Ruth Silv									2. Date of Dea	25	ay 201 ^{Year}	3. Time of Death 11:40 p M	
0	Medic Examin		4a. Facility Name (if no Holy Cross	ot institution, give st s Hospita	reet and number)			-		Location (40	c. County of Dea	ath	
	Funeral Director		5. Social Security Num 131–26–79	34 6. Sex	М 2 🔀 F 7. А	ge (In yrs. la	ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs.	8. Date of Birt 6 /6 /1 9 3	h Year)		rthplace (State or Foreign ountry) NY	
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9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 Ē	2 Married	2. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.)	If	Yes, spec	ify Cuba	spanic Ori n, Mexicar Specify:	n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify: Wh		
Baltimore, Maryland 21215-0036	vithin 72 hou liene. Ir than "natu the Medica	Completed		15. Decedent's Edu fy only highest grade day (0-12)		5+)	life. DC		rk done d retired)		t of workin	g		Kind of Business Versity		Ī
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imore	Page 1 arment of Herant: If iter		20a. Method of Dispos 1 ☐ Burial 2 🗗 4 ☐ Donation 5	sition Cremation 3 R Other (Specify)	emoval from State	20b. P Ches	lace of Dispos emetery, crem sapeake	ition (Nan atory or o Cre	ne of ther place mato	ry ([⊅] 4/26/	2011		ocation - City o		
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C	Physician/ Medical Examiner		Immediate Cause (Fin disease or condition resulting in death)	ailure. List only one nal	cause on each lin	on Car	ncer	the mod	e of dying	j, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death	
760 M	cate be executed physician and s the burial-transit	edical Examiner	Sequentially list condi- if any, leading to imme cause. Enter Underlyin Cause (Lisease or in in- that initiated events resulting in death) Las	ediate ng jury c	Due to (or as											
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Mec	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2基 N 9 ☐ Unknown	nths?	c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 🗌 Feta	I death 3 🗌	Ectopic p Other (sp		У				23d. Date of de Month	elivery Day Year	
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Division of Vital Records, P.O.	The law requate has bee page 2 shou	Completed										24a. Was a autop perfor	rmed?	prior to death?	utopsy findings available completion of cause of	_
ital	sician: certifica irector, p	Be	25. Was case referred to examiner?	<u> </u>	spital:				Otho	p	th (Check	only one)				_
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Divisio	al or Attend s after death I Director: /	Certificate:		Investigation G Could not be determined	28e. Place of Inj building, et	ury - At hoi c. (Specify)	ne, farm, stree					8f. Location (S City or Tow			ural Route Number,	_
_	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2 📙	Certifying Physic Medical Examine Certifying Nurse	r: On the basis of	examination	and/or investig	ation, in r	my opinio	n, death oc	curred at t	he time, date a	nd place	e, and due to the	cause(s) and manner state	∍d.
	To t. with To tl		29b. Signature and title	e of certifier	Rhe			29c	D 6	number	05			ate signed (Moni		
	1/0		30. Name and address Asuisu Tol:	of person who conica; 1500				lver	Spr	ing,	MD 2	0910				
	Stat		31. Date filed (Month, E	Day, Year)	32. Registr	aris Signat	re 23									. ~

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amend items 20a-c per fh s915 5-6-11 with State of Marvland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRI 201 Medical 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johnstocking Bax Views are TIMORE If Unde Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 🗆 M 2 💢 F Months Hours (Month, Day, Year) 90 Maryland 1921 Director 214-14-2702 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Dundalk 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21222 3314 McShane Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev William Kahler Lola Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3314 McShane Way Dundalk, MD 21222 Earlene Lake /Daughter 20c. Location - City or Town, State Baltimore, Beltswille, Ma. 20a Method of Disposition 20b. Place of Disposition (Name of Balt'Imore' Nat'l' pla Cem. May 1 X Burial 2 Gremation 3 Removal from State Maryland 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses MO1585 22. Nan@nematriconFamilia Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 Tobocca 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Intravascular Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) YEARS been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ☐ Yes ☐ Unknown Hospital or Attending Physician: The law requires that 124 hours after death. Funeral Director: After this certificate has been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Depression NXLC Records, 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performe **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၟႄ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Type 4940 Sastern MeNessa , MD ratth 32. Registrar's Sig 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death A Month 3. Time of Death Physician/ 3:45 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Wising 211 a timove or b + th 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) June 24, 1934 1 M 2 XXF Months 216-28-3594 Yrs. Director 76 Usual Residence of Deceder 10b. County death with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Tyes 2 XXNo E1kridge MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be i Funeral 6193 Rowanberry Dr 21075 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Yes 2XX No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2NX No Specify: "natural", Specify: Completed 3 Widowed 4 Wivorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carmelita Filter Edward Bandelin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 2nd Ave, SW, Glen Burnie, MD 21061 <u>Jack Steele</u> Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State MAy 4, 2011 Baltimore, MD Holy Cross Cemetery 4 Donation 5 Other (Specify) f Funeral Service I 22. Name and Address of Facility Fink Funeral Home, P.A. Gregory Fi 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 Part 1. Enter the disease, or shock, or heart failure. List of nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 111-2 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Ducito (or as a c or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit mortellsion Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform after death.

Director: After this certificate 2 No Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

State

Name and address of person who completed pause of death (Item 23a) (Type, Print) 320

31. Date filed (Month, Day, Year)

2115671

32. Registrar's Signature

				ype or Print in I				•	•	•
			For State	State of Marylan				∕lental Hy	giene	13841
		_	Registrar		Cer	tificate of l	Death	1	Reg. No.	10041
	Physicia Medic		Decedent's Name (First, Middle, Last)	Josephine	Con	cetta S	presser	2. Date of Dea Month April	Day Year 21, 2011	3. Time of Death
about of	Examir	ner	4a. Facility Name (if not institution, give str 4210 Belmar Ave			4b. City, Town, o B	r Location of Death altimor	е	4c. County of Dea	th
	Funeral Director		5. Social Security Number 212-34-3570 6. Sex 1 Usual Residence of Decedent	M 2 🔀 7. Age (In yrs. le 73	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 0 4 / 1 4	9. Bi (, Yea <i>r</i>) (, 1938	rthplace (State or Foreign buntry) MD
	Maryland 28a-f show otified at	Director	10a. State MD 10b. County	10c. City	, Town or Lo	cation	Balti	more		10d. Inside City Limits 1 Y Yes 2 □ No
	s 23a or ust be n	Funeral D	10e. Street and Number 2232 Essex S	treet		10f. Zip Code 2	1231		10g. Citizen of What C	ountry? USA
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	I	Vas Decedent of H FYes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify Whi	te, etc.
Maryland 21215-0036	iin 72 hou ie. han "natı • Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give A	O NOT use retired)	during most of work		16b. Kind of Business	
721	d with Hygier ther t	Be C	12 17. Father's Name (First, Middle, Last)			Factor	y Worke		Distil	lery
yland	should be file and Mental I 7 is marked o raumatic eve	To E	George Martin				18. Mother's Nam Jenny	e (First, Middle, J y Gal.	Maiden Sumame) LO	
, Mar	nd 2 shot ealth and m 27 is n		19a. Informant's Name/Relationship (Type, Raymond Spresser	^{Print)} Son					r, City or Town, State, Zi le, MD 21	
Baltimore,	t. Page tment c tant: If ijury or		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Fir	emetery, crem nal Jou	sition (Name of natory or other place ITNEY CTE	em. 4/		20c. Location - City of Woodbine,	
Bal	permit Depar Impor any in once,		21. Signature of Funeral Service Licenses	Dorota Marsh	all 22	Name and Address	ss of Facility and Crem	ation	Services	11202
	Physician/		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one climmediate Cause (Final disease or condition	Lung c	e-es	,			nore, MD 2	Approximate Interval Between Onset and Death
	Medical Examiner	L	resulting in death) Sequentially list conditions, b.	Due to (or as nsequ	ence of):					
8	executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Gause (Disease or implay that initiated events c.	Due to (or as a consequ	ence of):					
90 20 20	cate be executed physician and s the burial-transit	न	resulting in death) Last	Due to (or as a consequ	ence of):					
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣No g □ Unknown	If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnand Other (specify)	cy		23d. Date of de Month	elive r y Day Year
s, P.O.	requires that the dea been signed by the a should be detached	d by P	Part II. Other significant conditions contr	buting to death but not resu	ulting in the ur	nderlying cause giv	ven in Part I.		obacco use contribute to	o the cause of death?
Division of Vital Records,	he law requ te has beer age 2 shou	omplete						24a. Was a autop perfor	prior to death?	utopsy findings available completion of cause of
E E	ian: T ertifica ctor, p		25. Was case referred to medical examiner?			26. PI	ace of Death (Check	1 \(\superset \text{Yes}\)	ZAJNOJ ILIYE	s 2 No
<u> </u>	Physic this ce al dire	유	1 Yes 2 No Hos	pital:			4 U Nursing Ho		ence 6 XOther (Spec	pièce 3
0 UC	nding I tth. : After e funer	cate	1 A Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work M 1 🗆	y at :? Yes 2 🗆 No	28d. Describe ho	ow injury occurred	
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	I Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S: City or Town	treet and Number or Run, State)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 L Medical Examiner	nn: To the best of my knowle On the basis of examination ractioner: To the best of my	and/or investi	gation, in my opinic	on, death occurred at	the time, date ar	nd place, and due to the	cause(s) and manner stated.
	vithi To th		29b. Signature and title of certifier	Charles Rud Professor of	-MD PL	D 29c. License			29d. Date signed (Mont	
			30. Name and address of person who com	pleted cause of death (Item	23a) (Type, Pi	Int) Johns	Hooking	Higratel		· · · · · · · · · · · · · · · · · · ·
	Stat	e	31. Date filed (Month, Day, Year)	Ludin MDPL \$2. Registrar's Signatu		401 N	, Boadin	7 Ave,	1se throng 1	ND 21231
	- Julian		ADD 9 0 2011	D	100,1	V. 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2011 Physician/ Seibert J. Jr. 26, 8:00 P M April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson Social Security Number **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 1 🔀 M 2 🗆 F 214-30-7114 March 7 Maryland 1935 Director 76 Usual Residence of Decedent show filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 XNo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1957 Sue Creek Drive 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 10 years Transportation Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard J. Seibert Sr. Sophia Figuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Haislett Daughter 1957 Sue Creek Drive, Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of April 30, 2011 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place Department or Important: If any injury or St. Stanislaus Cem. Baltimore, Maryland Signature of Funeral Service Licenses ²². Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. whove 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Due to (or as a consequence of): disease or condition MUSCOMA Years Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? 1 Yes 2 No **Director:** After this certific d in by the funeral director, 25. Was case referred to medical a 26. Place of Death (Check only one) examiner? Hospital: Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 1 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Nature, 2 Accident Suicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat dress of person who completed cause of death (Item 23a) (Type, Print) OMNUES M 6701 31, Date 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Edwin Taylor 11:10 P.M 2011 26 April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 19 7 19 23 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**x** M 2 □ F Balt. Maryland **Director** 216-16-8421 87 Yrs Usual Residence of Decedent 28a-f show 10a State 10b. County with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Columbia 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **United States** Funeral 6336 Cedar Lane Apt. 250 21044 of America filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married 2 No Maryland 21215-0036 white 1 ☐ Yes 2XX No Specify: Completed 3 XXVidowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Engineering event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ permit. Page 1 and 2 should be Department of Health and Ments Important: If Item 27 is marken any injury or act. Adam Miller Taylor Ruth Hatch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Hedgewood Road Lutherville, Maryland 21093 Jean T. Zaleski/ daughter 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April^{Da}Ž8. 1 Burial 2 Cremation 3 Removal from State Evans Funeral Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chapel- Bel Air 21. Signature of Funeral Service Licensee Reaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ neum onla disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). that initiated events y physician ar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown á signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes peen 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s prior to completion of cause of death? autoos 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nospile 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year

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nd address of person who completed cause of death (Item 23a) (Type, Print) NANNUES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2^{Day} 20^{rear} Roger Ervin Tompkins 3:00 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Nursing & Rehab. Ctr. Sykesville Carroll Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Oct. 27, 1942 VΑ **Director** 68 216-40-5023 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Frederick Union Bridge 10e. Street and Number 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be n 10f. Zip Code 10g. Citizen of What Country? by Funeral 13120 Good Intent Rd. 21791 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify: and Mental Hygiene. Is marked other than "natural", Specify: white 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) heavy equipment operator construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Arlie J. Tompkins Pearl Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Tompkins/son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 13120 Good Intent Rd. Union Bridge, MD21791 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gard. 4/28/2011 Frederick, MD e of Forneral Service Lie 22. Name and Address of Facility Hartzler Funeral Home garine a New Windsor, MD 21776 P.O. Box 249 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on ea One and Death Immediate Cause (Final Motostofic Ph, sician/ Cauces disease or condition resulting in death)) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year cate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ב Puneral נ Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the F 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

32. Registrar's Signature

Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27, 2011 10:27岁 April Charlotte Ticha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 2209 Greenmill Road Finksburg Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Unde **Funeral** Country) Maryland 1 M 2 K F Months Days Hours Min. Feb 26, 1920 377-12-6747 **Director** 91 Usual Residence of Decedent or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 21 No Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2209 Greenmill Road 21048 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Examiner ı Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 ▼ Widowed 4 □ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Lindquist Laura Smitson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Ticha Daughter 2209 Greenmill Road Finksburg, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet. 5/4/11 Owings Mills, Maryland 21. Signat of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road le FUNERAL HOME Reisterstown, MD 21136 ELINE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 400 Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 1 Natural 5 Pending 1 Tes 2 No 2 Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

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29b. Signature

only one

and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ADELINE TORCHIA APRIL 26 2011 P M 9:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 3232 PEVERLY PLACE **ABINGDON** HARFORD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birtrips... Cou*ntry)* **NY** JAN 17, 1924 Months Days Hours Min Director 87 084.16.3220 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1**XX** Yes 2 □ No HERKIMER FRANKFORT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 611 REESE RD. 13340 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces 1 Ves 2 No Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Completed by Baltimore, Maryland 21215-0036 1 Tes 2 XXNo Specify: If Yes, Give Specify: WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 DIETARY DEPARTMENT HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SAM GRAZIANO MARY CORTALE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILIP TORCHIA 611 REESE RD. FRANKFORT, NY 13340 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 Cremation 3XX Removal from State 4 Donation 5 Other (Specify) WIN MT OLIVET CEMETERY FRANKFORT, NY 21. Signature of Funeral Service Liq 22. Name and Address of Facility FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. GREGORY FINK

Ph sician/ Medical

Examiner

physician and s the burial-trans page 2 s

the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition resulting in death)	e ENDS	+AgE Dener	tin		Onset and Death
	resulting in death)	Due to (or as a consequence of):				
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Justo (or as a consequence of):				
alcai Exe	that initiated events resulting in death) Last	c. Due to (or as a consequence of): d				
iysiciari/ime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
ten by F		contributing to death but not resulting in the un				the cause of death?
Compre				24a. Was an autopsy performed?	prior to o death?	opsy findings available ompletion of cause of 2 \square No
מ	25. Was case referred to medical examiner?		26. Place of Death (Che	ck only one)		
2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing F	Home 5 Residence	6 Other (Specif	(y)
III Cale:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be		28c. Injury at work? M 1 Yes 2 No	28d. Describe how inju	ury occurred	
200	4 Homicide determined		et, factory, office	28f. Location (Street a City or Town, Stat		al Route Number,
Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	vsician: To the best of my knowledge, death or niner: On the basis of examination and/or investi rse Practioner: To the best of my knowledge, de	gation, in my opinion, death occurred	at the time, date and place	ce, and due to the ca	ause(s) and manner state
	29b, Signature and title of certifier		29c. License number	29d D	ate signed (Month	Day Year)

W. MACPHAIL BELDINMD 21014

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

completed within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALGRAD SPANUS

31. Date filed (Month, Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25^{pay} O Month Elizabeth Caldwell Talford-Scott 20 m 7:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2417 Woodbrook Ave. Baltimore N/A 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 STF Months Days Min. Hours 212-26-4267 95 0270877916 S.Carolina **Director** Yrs Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a o Funeral 2417 Woodbrook Ave. 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) self 6th Grade House Keeper- Artist other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ပ္ Samuel Caldwell Mary Jane Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Joyce Scott(daughter) 2417 Woodbrook Ave., Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State of o ☐ Burial 2X Cremation 3 ☐ Removal from State ò Department of Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 05/02/11 Baltimore, 21. Signature of Funeral Service Licensee ²²Joseph dreft of Fabrown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD21217 Part 1. Enter be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nmediate Cause (Final Onset and Death Physician/ STHEE disease or condition resulting in death) Medical Due to lor as a consequence of): Examiner MONI Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown the Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29c. License number person who completed cause of death (Item 23a) (Type, Print) 2300 State Registrar

Please Type or Print in Black Indelible Ink. 57 syre All Capies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ ^{Day}28<u>,</u> 4:54 PM 2011 John Clarene Vena Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Lutherville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **⊠** M 2 □ F (Month, Day, Year) **May** 08, Months Davs Hours 63 Director 218-44-7253 Yrs 1947 Pennsylvania Usual Residence of Decedent 10a. State 10b County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Harford 1 Yes 2 No Edgewood 10e. Street and Numbe ö items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 907 A Woodbridge Ct. 21040 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian, Armed Force 9 þ Black, White, etc. 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural" Completed 3 Widowed 4 Divorced Specify White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Construction Laborer traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Unk Unk John Vena Jr. Unk Unk Rhea Margaret Hibner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Craig Falagna /Friend Fallston, MD 21047 2727 Harford Road Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Apr 29 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives Hac MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) MALIGNANT MELANOMA Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Dus to (under a concequence of): that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate Yes 2X No 1 Yes Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 Tes Other: ျာ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Accident
Suicide 1 Tyes 2 🗌 No Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of per n who completed cause of death (Item 23a) (Type, Print) 0 JACKIE JONES, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 State

Registrar

2011

28,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Registrar 1. Decedent's Name (First, Middle, Lest)		partment of Health and 18/2011 dhb ertificate of Death	2. Date of Dea	ath	3. Time of Death
Physician /Medical	JOHN 4a. Facility Name (If not institution, give stre	pet and number)	4b. City, Town, or Location of Dea	April	Day Year 4c. County of Death	14:48 M
caminer	The Johns Hopkins Hos		Baltimore City			
eral ctor	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthda 68 Yrs.	Months Days Hours Mir	s. 8. Date of Birth (Month, Day Aug. 1	(Year) Count	lace (State or Foreign y) MD
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		1	0d. Inside City Limit
ctor	MD Baltimor	re	Middle River			1 Tes 2 XN
al Dir	10e. Street and Number 6839 S. River D	rive	10f. Zip-Code 21220		10g. Citizen of What Count USA	ry?
by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 XX'es 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue □ Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)		
Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Completed) (G. life	cedent's Usual Occupation ive kind of work done during most of w e. DO NOT use retired) Yard Master	orking	16b. Kind of Business/Ind	dustry
Be Co	17. Father's Name (First, Middle, Last)	171		ame (First, Middle,		
10 8	John H. Wehner		Barb		Schnider	Cada
	Carol A. Wehner		339 S. River Dr		•	
	20a. Method of Disposition 1 Render Street Burial 2 □ Cremation 3 □ Render Street Compared to the street Co	noval from State cemetery, o	sposition (Name of trematory of other place)	Date 19/11	20c. Location - City or To	
	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of un ral Service Licensee	O O	22. Name and Address of Facility	Contract of the Contract of	e Ave. Bal	
	I toled Teen	Connelly V	Connelly Fu	neral H	ome of Ess	ex 21221
	23a. Part 1. Enter the disease, or complete shock, or heart failure. List only the Immediate Cause (Final disease or condition	cause on each line.	enter the mode of dying, such as card		rrest,	Approximate Interval Between Onset and Death
edical Examiner	Sequentially list conditions, from a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	CERTIFICATIO	APHROVED BY MED	DICAL EXAMINER	
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ory Day Year
<u>ه</u>	Part II. Other significant conditions contri	buting to death but not resulting in th	ne underlying cause given in Part I.	23e. Did to	obacco use contribute to the	
Completed				24a. Was a autop perfor 1 Yes	24b. Were auto prior to co med? prior to co death? 1 \sum Yes	psy findings availabl mpletion of cause of 2 No
To Be	25. Was case referred to medical examiner? 1 XYes 2 400	spital: 1 Inpatient 2 ER/Outpat	Other:	eath (Check only or Home 5 Resid	ne) Ience 6 🗆 Other (Specify	· · · · · · · · · · · · · · · · · · ·
	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju		28d. Describe h	now injury occurred	
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Town	Street and Number or Rura n, State)	al Route Number,
			eath occurred at the time, date and pla r investigation, in my opinion, death oc			
dica		7.			29d. Date signed (Month,	Day, Year)
Medical	29b. Signature and title of certifier	mo	29c. License number D006463		April 14, 20	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department of Health and Mental Hygiene 1- Registrar	0
4	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death AND Day Tear 1. Time of De Anouth Day Tear 1. Tear 1. Tear Tear 1. T	
	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	<u> </u>
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fi	oroign
4 - -	Funeral Director		216-50-1279 12 M 2 F 63 Yrs. Months Days Hours Min. Apr. 18, 1947 Maryland	ərəigir
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	imits
	e Mary 3a-f sh	ctor	Maryland Harford Bel Air	X No
	with the	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2207 Brynes Court Apt. H 21015 USA	
	death ms 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. If mar 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at	by Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates:	
5-0	72 hou natura		15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	
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	ould be filed within Mental Hygiene. arkad other than atic avant, the Ma	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	2 should be and Menta is marked	To E	John Rhodes Webb Katherine Ann Scott	
	and 2 sho ealth and n 27 is my		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Justin Webb/ Son 604 Cider Press Loop, Joppatowne, MD 21085	
Baltimore,	Pages 1 and 1 nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Itim			4 Donation 5 Other (Specify) Hilltop Service Corp 4-25-11 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A.	
Ba	permit. Departr Importe any inje		Stephe a Weeky 1317 Cokesbury Road, Abingdon, Maryland 2100	09
Ag.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Consett and Peach Consett and Pea	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) TNTRA CRANIA HETOIRCHAGE Onset and tree Conset and tree C	45
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	rted nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury	
oʻ	e execuien and	Exar	that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER d.	
9289	icate be executed physicien and s the burial-transit	dicai	d. CERTIFICATION APPRIOR	
Box 6	eath certific attending p	ın/Me	IF FEMALE: 23b. Was decedent pregnant is the past 13 months? 23c. If yes, outcome of pregnancy 1	
O. B	at the deal by the att tached fo	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	.r
Δ.	es that igned b	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	th?
ord	w requir been si should	eted	1 Yes 2 No 3 Probably 4 Monk	
Vital Records,	The law requires that the death certificate be executed take has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed	24a. Was an 24b. Were autopsy findings ava autopsy performed? 1 Yes 2 No 1 Yes 2 No	illable se of
Vita	Physicien: this certificated director, p	Be	25. Was case referred to medical examiner?	
o		n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
sion	Attanding I r death. ector: After by the funer	atio	2 Accident investigation M 1 Yes 2 No	
Division	al or Attandir s after death. sl Director: Al	Certification:	3 Suicide 4 Homicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Street and Number or Rural Route Number of Street and N	ζ,
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	To tha Vithin 2	Me	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)	i
)		Josh Cosh, MD 142634 /1pr.1 17, 201	/
+			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. SEPT- COETA SOIST PALL PLACE BACTINE, 1) 212.	01
*	Sta Registr	1	31. Date filed (Month, Day, Year) APR 2 8 2011	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 26 Day 2011 5:15 A M Waddel] <u>Herbert</u> Arthur Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 21 Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In yrs. last birthday) Days 1 ፟፟፟ M 2 □ F **Director** 218-30-6631 88 Marvland show filed within 72 hours after death with the Maryland 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland New Windsor 1 X Yes 2 No Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Lambert Ave. 21776 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc o. ģ 1 Never Married 2 Married Yes, Give Maryland 21215-0036 2 🔀 No 1 ☐ Yes 2X No Specify. Completed 3 XWidowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) farmer dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of ပ should be S. Benjamin Waddell Emma Stuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Edward L. Waddell/ son 5121 Harpers Farm Rd. Columbia, MD 21044 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winters Cemetery 4/30/2011 New Windsor, MD 21. Sign the of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home attarine (310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any hading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to for as a consection of b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown PNEUMONIA 24b. Were autopsy findings available prior to completion of pause of death?

1 Yes 2 No 24a. Was an autopsy performed? 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Fother (Specify) 1 PRATEM 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760 P.O. Records, **Division of Vital**

DHMH 17 Rev 7/2009

State

Registrar

Medical

29a. Certifier

29b. Signature

(Check only one)

and title of certifier

<u>Flavio Kruter</u>

APR 29 201

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's gnature

555 S.

🕆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Center St

29d. Date signed (Month, Day, Year)

Westminster, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year ADRI 201 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death LORRAIN Im HUENUE OR If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-36-011 **№** 2 🗆 F Months Hours (Month, Day, Year 2/23/19 Director AND Usual Residence of Decedent of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firem 27 is marked other than "natural" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Xes 2 No MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral LORRAINE U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No 1 Never Married 2 Married Yes 1 ☐ Yes 2 No If Yes, Give Specify: Specify: BLACK 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) BALTIMORE C College (1-4 or 5+) ACKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 ANNA LURRA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 29 ZOII BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service Lib DERRICK C. JONES FIH, P.A. MARILITA Approximate Interval Between other and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory Immediate Cause (Final Filysician disease or condition resulting in death) KINK Medical Due to (or as a conseq Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Date to (or as a nonsequence of within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 [ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical The Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

State

STAWLE

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 25° James Andrew Wilkes 2011 9:48 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 429 Carol Ct. Glen Burnie Anne Arundel County Social Security Number 6. Sex 1 ★ M 2 ☐ F If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Hours 1*2*//12/1941 **Director** 219-38-4501 69 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland and Mental Hyglene. 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Co. Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 429 Carol Ct. 21061 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: marked other than "natural", If Yes, Give 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transport Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew James Franklin Wilkes Rosanne D. Haskell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola M. Wilkes/Wife 429 Carol Ct. Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 28, 1 🗔 Burial 2 🕱 Cremation 3 🗔 Removal from State Beltsville, MD Chesapeake Crem. Inc 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown certificate has been signed by trector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy perform prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital မှ 1 Tes 2 I 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Desidence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month. Dav. Year) 26

Registrar

State

ted cause of death (Item

32. Registra

Type, Print) Madlym

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State

Registrar

Theodore A. Stephens,

31. Date filed (Month, Day, Year)

APR 29

32. Registrar's Signature

M.D. 1005 North Point Blvd, Suite 724, Baltimore, MD. 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3855 Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death 2. 2011 Physician/ Month Anderson Vivian E. April 22, 10:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany Country House Residence **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Maryland Months Days Hours Min Marth, Dev, 88 ¶923 Director 218-40-3115 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits PΔ Bedford 1 🗌 Yes 2 🏝 No Bedford Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 161 Anderson Dr. 15522 U. S. A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Own Home Be permit. Page 1 and 2 should be filed beatment of Health and Mental Hyg Important: If item 27 is marked othan injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Reese Zembower Lola (Cessna) Zembower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark E. Anderson 161 Anderson Dr., Bedford, PA 15522 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 **Cremation 3 ** Removal from State 4 Donation 5 Other (Specify) Anderson Farm Cemetery Unknown Bedford, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hafer Funeral Service, 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) as a consequence of). Examiner ismemile cequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): the burial-transit physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death Year g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 □ No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0td 2000 Registrar's State APR 29 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. 3. Time of Death Physician/ Katherine Alice Aarthun : 20AM Medical PYLL 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7425 Campbell DR. Anne Arundel Severn 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MN 1 🗆 M 2 🏝 F Months Days Hours Min 473-20-4653 Director 89 671871921 Yrs Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Miportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel 1 Yes XX No Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7425 Campbell Drive 21144 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Max Treu Amy Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jergen Russell Aarthun Spouse 7425 Campbell Dr. Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/14/2011 Glen Burnie, MD Signature of Fundamental Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. Date Annapolis RD. Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CAR DIOMYOPA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the burial-transi Cause (Disease or linjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ERTICULITIS Completed 2√1 No 3 ☐ Probably 4 ☐ Unknown 1 Yes peen 24a. Was an Were autopsy findings available has autopsy prior to completion of cause of death? perform 24 hours after death. Funeral Director: After this certificate Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 🗌 Yes Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Assidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2011

State Registrar

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noh 31. Date filed (Month, Dav. 21108

Veterans

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 2011 HELEN EARNSHAW ABNER 0308 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE'S OUEEN CORSICA HILLS CENTER CENTREVILLE 7. Age (In yrs. last birthday) 6. Date of Birth g. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🔀 F Hours Min. WASHINGTON D.C **Director** 08/02/1913 265-28-1082 Usual Residence of Deceden or 28a-f show 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 1 Yes 2 X No CAROLINE MARYLAND DENTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8475 DEER RUN ROAD 21629 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2**X**☐ No Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INSURANCE SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, FRANK EARNSHAW LOTTIE MAE KELLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8475 DEER RUN ROAD, DENTON, MD 21629 EARNEST M. GOULD/SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State EDGEWATER, MD 04/14/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Doath Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 70 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s prior to completion of cause of death? performed Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other 2 🖺 🕠 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔁 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o certifie 20 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) US Di Durato Drive Charles 31. Date filed (Month Pay egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:10 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 🗆 M 2 🗶 F 64 304-48-8205 Director April 26, 1946 Missouri Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 1407 Hunting Horn Lane 21703 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: , or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ White 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within on Mental Hygiene. College (1-4 or 5+) Business Owner Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Austin G. Miller Nancy Eyre Weber ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 David J. Bloomenstock / Spouse 1407 Hunting Horn Lane, Frederick, Maryland 21703 Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Saint John's Cemetery April 26, 2011 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Keeney & Bastord P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and d for use as the burial-tran Due to (or as a consequence of) 68760; Physician/Medical Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 1 Inpatient Other: $_4 \square$ Nursing Home 200 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 2 Accident Injury the Hospital or Attending 5 Pending investigation 1 🗌 Yes death. after death Director: filled in by the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

Registrar DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

Asnley

31. Date filed (Month, Day, Year)

30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print)

Helgeson

32. Registrar's Signature

Res-000

600 North Wolfe St, Baltimore, MD, 21287

Registrar

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 28b per me e917 7 7 18 11 Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Sylvia Greenfield Basil 400 TOYC Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince E earges Cheverla Hos DiTa Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2XXF Min. 127134 1932 78 212-30-9132 MD Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2XXNo 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r Funeral 1021 Bloom Ct. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify: Specify: Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Max Greenfield Frances Rae Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 Bloom Ct. John Basil Spouse Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once. 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillcrest Memorial 4/10/2011 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 2. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Intracrania disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hematona be 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed certificate has 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner2 Hospital 2 🗌 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28b. Time of UNK 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28c. Injury at work? s after death.

I Director: After the in by the funera injury 1 Natural 5 Pending home Late PMM 4/1/2011 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 21401 filled in by determined 1021 Bloom Ct. home 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00/ State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 per PHY AACO Health Dept 4-19-11 KAH

1 - State Registrar State of Maryland / Department of Health and Mental Hygiene, amenditem#20bperfun g916 all of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 April Darrel Cole Barfield Physician/ РМ Darrell Cole Barfield 2 9:05 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Feb. 4 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Year 9<u>49</u> CountryFlorida Hours 1 🛛 M 2 🗆 🕆 62 Director 261-94-4399 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at Director tX Yes 2 No Prince George's Bowie MD 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number USA "natural", or items 23a 20716 16207 Pointer Ridge Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces?

X Yes 2 \sum No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 1969–89 Year or Dates, 1969–89 Specify: 3 Widowed 4 Divorced White Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medicals once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Coast Guard Aviation Machinist 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mildred Keil Dewey Barfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34601 19a. Informant's Name/Relationship (Type, Print) 1071 Candlelight Blvd, Apt E66, Brooksville, FL Laura Barfield / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date UNK 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/22/2011 Arlington Nat'l Cem. : Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service L Bowie, MD 6512 NW Crain Hwy., r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause on each line. . Part 1. Enter the dise se shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 170 CC Sequentially list conditions, if any, leading to immediate Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit Cause (Disease or iinjury -tricular that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe , page , Yes 2 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 1 Natural 5 Pending work?
1 Yes 2 No death. 2 Accident 3 Suicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number HU0 70 481 Jale Dic 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60010 2000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1 2011 1:54 P M 6, Mary Margaret Belk Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min Mar. 27, North Carolina 1926 242-28-8917 85 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tes 2 No Prince George's Bowie Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20715 12811 Beechtree Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Velma Woods Walter Dewey Terry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Mainmast Circle Berlin, MD 21811 Teresa Masino/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4/9/2011 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant NO 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Pregnant at time of death signed by the a 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an cate has page 2 s prior to completion of cause of death?

1 Yes 2 No certificate Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes ၉ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 \square Pending work?
1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one 29b. Signat 29d. Date signed (Month, Day, Year, 2 (Item 23a) (Type, Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle) Last) Month 15 AM Physician 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6/30/1941 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number **Funeral** Months Hours 1XEXM 2□F 69 NJ 156-28-9497 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes X2X No WV Hampshire Green Spring Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number Rt 1 Green Spring Valley Rd. 26722 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. MXYes 2 □ No
If Yes, Give
Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Tes 2√XNo Specify: ð 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Military 12 Pilot 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Harold Connor Grace Dickinson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Judy Merritt POA Rtl Green Spring Valley RD. Green Spring, WV 26722 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any injury or o 5/6/2011 Winchester, VA 4 Donation 5 Other (Specify) OMPS Cremation Svc 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events OH MPPROVED BY WEST Examiner The law requires that the death certificate be executed and for use as the burial-trai CERTIFICAT resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No the 9 I Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ should be 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 2 has 1 TYes 2 No Yes certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) Yes 2 🗌 No 2 ER/Outpatient 3 DOA Inpatient Certification: To After this 28d. Describe how injury occurred burning leaves Date of Injury (Month, Day Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? ignited subject's clothing 1 🗌 Natural 5 Pending investigation or Attending 1 📋 Yes 2XXNo Accident 3/19/2011 unknown death. filled in by the after death Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 26722 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home City or Town, State) 26722 HC 86 Box 12 Green Spring, 4 Homicide yard To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Atle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 APR 1 2 2011 31. Date filed (Month) 32. Redistrar's Signature State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 2011 Physician/ Month ZORA GREY DIXON 6:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA 5. Social Security Number Year If Under 24 Hrs 8. Date of Birth (Month, Day, March 22 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Hours Min. Year! Director Maryland Usual Residence of Decedent should be filed within 72 nous and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 23a or 28a-f show if is marked other than "data Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No VA Fairfax Fairfax 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 22101 1722 Chesterbrook Vale Ct USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes Give Specify. Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None None permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Thomas J. Dixon</u> Kalahn Taylor-Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Dixon/Father 1722 Chesterbrook Vale Ct. McLean, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🕅 Burial 2 🗌 Cremation 3 🔲 Removal from State Arlington Nat. Cem. 4 Dopation 5 Other (Specify) 4/8/11 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arlington, VA 22203 23a. Part 1. Enter the disease, or complication, that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ EXTREME PREMATURITY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛂 No Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2 X N Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify s after death.

I Director: After this d in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ■ Natural 5 \square Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number 25MA07382700 (NJ) April 1,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER

Registrar
DHMH 17 Rev 7/2009

State

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Maryland 21215-0036	hours vatura ical E	Completed		15. Deceden	t's Education	r or Dates.		16a. Deced	dent's Us	ual Occup	ation		16b.	Kind of Busines	s Industry	
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Jre,	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disp	osition				Place of Dispo	sition (Na	me of		1 ^{Date} 28,		Location - City of		ite
<u><u>E</u></u>	Page ment tant; I		1 🔀 Burial 2 ☐ 4 ☐ Donation			ai irom State	'	Olive	-	•			Fre	derick,	Mary	la <u>nd</u>
Baltimore,	permit. Page 1 a Department of B Important; If it any injury or of		21. Signature of Fun	eral Service Li	cyngee		2011				s Basior					
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B 0)	death he att	sici	in the past 12 m 1 ☐ Yes 2 N 9 ☐ Unknown		4 🗆	Pregnant a Unknown			Other (s				-	Month	Day	Year
o.	requires that the death been signed by the atte should be detached for r	, Ph	Part II. Other signifi	cant conditio	ns contributir	ng to death b	out not res	ulting in the u	nderlying	ı cause giv	ven in Part 1.	23e. Di	d tobacc	o use contribute	to the cause	e of death?
S, F	ires the signed of the contractions of the con	d by										_ 1	Yes	2 🗆 No 3 🗆	Probably	4 X Unknown
ord	v requ	lete										24a. W				lings available
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<u>la</u>	sian: T		25. Was case referre examiner?	d to medical							ace of Death (Cl		T.			
Ξ.	Physic this co	ピ	1 Yes 2	No	Hospital	1 🗌 Inpati		ER/Outpatier			4 LX Nursing			6 Other (Spe	cify)	
n 0	ding F h. After funer	ate	1 Natural 2 Accident	5 Pending	9	. Date of inju (Month, Da		injury	М	28c. Injury work		28d. Describ	e how inj	jury occurred		
Division of Vital Records, P.O. Box 68760	Atten or deal sctor: by the	Certificate:	3 Suicide 4 Homicide	Investig 6 Could r determi	ot be			me, farm, str						and Number or F	ural Route	Number,
Div	tal or rs afte al Dire		4 🖾 Homioido			building, et	c. (Specify	9				City or	fown, Sta	ite)		
	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the k	Medical												and manner as s		nd manner stated.
	the lithin 2 the lomble	M	only one) 3 29b. Signature and t		Nurse Practi	•			29	c. License	e number		29d I	se(s) and manner a Date signed (Mor	th. Dav. Yea	ar)
	⊢≯Fő			rllin		_				D 4-	1951		4	-22-	701	1
	0		30. Name and addre	ss of person v	/ho complete	d cause of c	death (Item	23a) (Type, F	Print)	Δ.	Ec	→ :	1	-22- MD 2	170	1
حفين			S IBTE	A KA	1,1HZ	MD	814	LOIL H	onse	- HU	e-TRA	EVERIC	15	-07 2		ι.
	Sta Registra		31. Dåtë filed (Month	2011	Bene	32. Registr	s Sign									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ - M KICHARD APRÍ 2-011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOS PITAL OUN If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ₺ M 2 🗆 F Months Days Hours Min Jan 25 1922 **Director** 215-05-5786 89 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD Kent Massey 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11670 Carroll Clark Rd. 21650 U.S.A. filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force δ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: "natural" Specify: Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Henry Dierker Minnie May Grulkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Spies (daughter) 7960 Dover Neck Rd. Easton, MD. 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) Massey Cemetery 4/28/11 Massey, MD. Si puture o Fund al Se 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 M00510 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause in each line. Interval Between Immediate Cause (Final Onset and Death NEUMONG Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Due to (or as a consequence of, Examin Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🔲 Yes ျ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce<u>rtifie</u> 29c. License number 200 Name and address of person who completed cause of death (Item 23a) (Type, Print)

TACOBS 100 13Kow 5M 17 CHESTERTOWN 21620 SMEET 32. Registrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12:30 A M MARGARET ANN DARLING APRIL 12, 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN KENT Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours 1 □ M 2 🔀 F 12/7/1922 88 218-48-6204 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD QUEEN ANNE'S SUDLERSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 21668 UNITED STATES 412 S. CHURCH STREET 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 □Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 □Yes 2X No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) JOHN SPENCER MARTHA JANE BEALE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALTON DARLING/SON 430 TRUSLOW RD. CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE CEMETERY 4/15/2011 | SUDLERSVILLE, MD 21. Signature of Fun ral Se FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Par 1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the com ns that caused the d Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Yes 2 No in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 XNO 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one, PNO Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

ar than "natural", or items 23a or 28a-f show

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed went of Health and Mental Hygiver: If Item 27 is marked other

Department of Health and M Important: If Item 27 is marl any injury or other traumationce.

Baltimore, Maryland 21215-0036

burial-tra

and attending physician for use as the buria cate has been signed by the page 2 should be detached

requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician:

24 hours a

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completely

Medical

State

Registrar

Examine Physician/Medical ≥ Completed Be Certification: To this funeral Hospital or Attending P
 24 hours after death.
 Funeral Director: After t After filled in by the

25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Feath Natural 5 Pending

Investigation 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) Injury

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed ca le of death (Item 23a) (Tvi

APR 13

strar's Signature

11-02669 Albert Duane Dento	1 R	AACO HEALI - For State AMEN Registrar	TH CMHSta ID#20c Pe	te of	Print in B Maryland 4/11/2011	/ Depa	delible l irtment of	Heal	th and	All Co	opies A al Hygie	ene	gible		Approximate de la constante de	1386	9
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Funeral Director		5. Social Security N		S. Sex	7. Ag	ge (In yrs. Ia	st birthday) Yrs	Month	er 1 Year is Days			Date of Birt 3-19-1		l r	oreian	place (State or ntry) MA	
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r death with thnr items 23a.c.		11. Marital Status Never Marri		1 rried	Was Deceden Armed Forces			s Decede	ent of Hisp	oanic Origi	in? (Specify Puerto Rica	Yes or No-		14. Race White,		an Indian, Black,	_
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MD 21 d 2 should ith and Me n 27 is ma numatic cv		19a. Informant's Name/Relationship (Type, Print) Michelle E. Denton/ Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - City or Town, State 6201 Wood Pointe Dr., Glenn Dale, MD 20c. Location - Ci												20769			
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P.O. Bc es that the der igned by the ve detached for a by Physe		Part II. Other sign			9 Unknown	ith but not re	esulting in the	underlyin	g cause g	iven in Pa	rt I.			_	-	he cause of death?	_
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical Example.						· · · · · · · · · · · · · · · · · · ·					_ }	24a. Was autop	rmed?	pri de		opsy findings available ompletion of cause of	•
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Division o spital or Attending tours after death. Terral Director: After filled in by the funce Certification:		1 Natural 2 Accident 3 Suicide	5 Pend	ing tigation I not be	FOUND: Day Apr 7, 2011	,Year)	FOUND: 1514 hrs		1 Y	′es 2 ✓	No Sub	Location (ot by p	olice		al Route Number, City	,
Divisior Biopital or Attend 24 hours after death. Funeral Director: rely filled in by the 1al Certificatic		4 Homicide 29a. Certifier 1	deter	mined	(Specify) Lo			rred at th	e time, da	ite and pla	1		Dale Ri			n Dale, MD	1
Tn the Ho within 24 To the Fo completel	-	one) 2 🗸	Medicai Exa	niner: O	n the basis of ex nd manner stated	aminetion a		ition, in m		, death occ			and pla	ice, and du	e to the		_

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time of de	2 Fetal death sath 5 Other (Spe		Ectopic pregna	ancy	Month	Day	Year
Part II. Other significant conditions	contributing to death but not r	esulting in the underlyin	g cause (given in Part I.		cco use contrit	_	use of death?
				 	24a. Was an autopsy performs	pi ed? de		ndings available ion of cause of
25. Was case referred to medical			26.Place	of Death (Check	only one)			
examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursi	ng Home 5 Re	sidence 6 🗸	Other: Scene	9
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury FOUND: Apr 7, 2011	28b. Time of Injury FOUND: 1514 hrs		ry at Work? Yes 2 ✔ No	28d. Describe how Subject shot b		id .	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h		y, office I	ouilding, etc.	28f. Location (Stre or Town, Stat 11414 Glen Dale	e)		
(Oliotal Olin)	nn: To the best of my knowled On the basis of examination a					•		e(s)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

April 8, 2011

State Registrar

30. Name and address of person who completed fause of death (Item 23a)
Theodore M. King, Jr., MD. Assistant Medical Examiner 32. Registrar's Signature

Theodore M. King, Jr., MD.

31. Date filed (Month, Day Year) 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 201^{ea} Verna J. Ellis 10:26A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Months Days Hours 08-22-1940 241**-**72**-**4223 Director NC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🎦 No PA Delaware Aston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 19014 USA 2177 Bridgewater Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 Pent of Health and Mental Hygiene.
Int: If item 27 is marked other than "n
iry or other traumatic event, the Medi Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leila Pucket Jim Carlisle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Gail Cuffari/daughter 2177 Bridgewater Road, Aston, PA 19014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 04/21/2011 4 Donation 5 Other (Specify) Lawncroft Crematory Linwood PA ral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home P.A. 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF LIVER Physician CIRRHOSIS END STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 D sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 은 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1X Natural work? 5 Pending 2 🗌 No Accident Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO 65733 4/17/14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FLKNN HAZIGLI

DHMH 17 Rev 7/2009

State Registrar RA

NARMANA 31. Date filed (Month, Day, Year) V. PULA

32. Registrar's Signature

5 meet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	-	1 - State Registrar	Cei	tificate of Death		ı	Reg. No.	2011	138	170
Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Dea		OO11 Year	3. Time of	
Medic		Eileen M. Feeley				April :		2011 Year	7:00	Рм
Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location Crofton	n of Death			County of Death		
Funeral		1412 Houndhill Road 5. Social Security Number 6. Sex 7. Age (In yrs. le	ast birthday)		er 24 Hrs. 8	3. Date of Birtl	<u>1</u>	9. Birti	hplace (State o	r Foreian
Director		578-36-8558 1 □ M 2 X F 80	Yrs.	Months Days Hours	Min.	uq. 27	Year) 9:	30 Wash	ington	
MC .	. 1	Usual Residence of Decedent							40.1.1.0	
-fshr ied at	Director		y, Town or Lo	cation					10d. Inside Ci	ty Limits
r 28a notif	Dire	Maryland Prince George's Bow	1e	10f. Zip Code			10a Citis	zen of What Co		2 140
23a o st be	ral			20715			U.S		unitry:	
tems er mu	Funeral	13433 Overbrook Lane 11. Marital Status 12. Was Decedent Ever in U.S.		Was Decedent of Hispanic O				14. Race - Amer		
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tural' al Ex	Completed	3 🗓 Widowed 4 □ Divorced Year or Dates.			Specify: White					
n "na Aedic	nple	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during mo O NOT use retired)	ost of working		16b. Kir	nd of Business I	ndustry	
giene.		Elementary/Seconday (0-12) College (1-4 or 5+)		nistrator			F.	B.I.		
al Hyg		17. Father's Name (First, Middle, Last)		18. Mot	ther's Name (F	First, Middle,	Maiden S	Surname)		
Menta arkec atic e	ပ	William Monaghan		Flo	rence	<u>McMaho</u>	n			
raum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number Houndhill Ro						
Health em 2 ther t		John Andrew Feeley/Son 20a. Method of Disposition	lace of Diene	ecition (Mame of	Dat			cation - City or		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 XBurial 2 Cremation 3 Removal from State	emetery cre	natory or other place) Teaven				•		ח
artme ortan injun		4 Donation 5 Other (Specify)	etery	2. Name and Address of Fac	04/19	<u>/2011 </u> ert F	511 Eva	ver Spr ns Fune	ral Ho	me D
any poor			- 1	5000 Annapoli						
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Medical xaminer		resulting in death) a. Due to (or as a consequ		-	1818					0
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completed filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1. Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination								anner stated
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viti cor		29b. Signature and title of confidence		29c. License number	18		29d. Date	e signed <i>(Month</i>	i, Day, Year)	2//
8 .		20 Name and address of some who completed some of do the	232/15	Print	, 0		1171	104 -	10)00	- 1 /
Of		30. Name and address of person who completed cause of death (Item STANDS)		EDICAL PLY	ANI	VANU 4	s n	m 21	401	
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signat								
Registra	ar .	APR 1 4 2011	1 1	arked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ Day 07 Year 201 1:29 Anne Medley Ford Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BURNIE ARUNDE Baltimore Washington Medical Center GLEN ANNE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 **X** F Mar. 1920 91 Washington, DC Director 577-18-0547 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits by Funeral Director 1 Yes 2 No Maryland Anne Arundel 0denton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21113 USA 1212 Odenton Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of Mary Louise Edwards Miles Michael Sugrue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 1417 Olde McKenze Dr. Holly Springs, NC 27540 Patrice Shaw/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Washington ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/9/2011 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 Ula 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ASPIRATION PNEUMONITIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes ∠ □
9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEUMOTHORAX 1 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an this certificate has ral director, page 2 autopsy prior to completion death? Awithin 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ဂ္ 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 V Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9090 201 and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Washington Medical Center, Glen Burnie, TARAK REDDY gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4/11 2011 1049 <u>Janice Diane Gambino</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Arunde1 Anne 5. Social Security Number If Under 1 Year 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🎞 🛣 Days Min 9/4/1958 Hours 128-52-5326 52 Yrs. **Director** Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 No MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 1448 Ridgeway USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ò 1 Never Married 2 Married 1 Yes 2 XXVo If Yes, Give Year or Dates. Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. er than "natural", the Medical Exar 3 Widowed 4 KNDivorced Specify Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Education Teacher permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Richard Gambino Patricia Podmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Westport Ave. #200 Norwalk, CT 06851 Sister Donna Gambino Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Philip the Apostle 4/19/2011 Ashford, CT 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fune al Service License 22. Name and Address of FacilityHardesty Funeral Home, Dat 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ vetraceve by disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner anayto pen. Sequentially list conditions, Due to (or as a consequence of) if any, leading to himmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and I-transit mphon that the death certificate be executed Due to to as a consequence of resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day the 9 🗌 Unknown g Unknown P.O. I been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Yes or Attending Physician: of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes Other: 2 No မ 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after death.

Per Funeral Director: After the pleted filled in by the funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Division ☐ Accident☐ Suicide Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical

completed within 24

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State Registrar 29a. Certifier

29b. Signatur

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APR 1 4 2011

Certifying Nurse Practioner:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

AnneAmo

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D000 58297

29d. Date signed (Month, Day, Year)

redical Center AnnapolisMD 21401

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me,g914,04/28/2011dhb
Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAM N/M/NHARRY MARCH 28, 2014 2:25A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST. MARY'S HOSPITAL ST.MARY'S LEONARDTOWN 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours WASH., D.C. 87 (Month, Pay, Year) 2 4 Director 578-22-0051 Usual Residence of Decedent s 23a or 28a-f show ust be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD. ST.MARY'S CHARLOTTE HALL 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 CHARLOTTE HALL RD. **Examiner must** 20622 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decement — Armed Forces?

1 Ares 2 NoARMY

Was Give WWII 14. Race - American Indian, Black, White, etc. Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.

Lant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRICIAN SUPERVISOR 10th U.S.GOVT. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM S. HARRY ANN L. CROPP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT W. HARRY-SON 3965 LEE LANE WHITE PLAINS, MD. 20695 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or c 1 X Burial 2 Cremation 3 Removal from State ARLINGTON NAT. CEM. ARLINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Meral Service Licenses M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death KESPIRATOR Physician/ AILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FUMONUA ATTON Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events.) Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER signed by the attending physician and d be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a, Certifier ▶ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MARCH 26, 2011 icea guin D26344

Registrar
DHMH 17 Rev 7/2009

State

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ST. MARY

HOSPITAL

LEONA ROTCHUN, MARYLAND

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

PATRICIA 6 31. Date filed (Month, Day, Year) , md

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mony Medical 4a. Facility Name, (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 100 HAMPTON ANNE ARI If Under 1 Year Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗹 F Months Days Min Month, Day, Hours OYrs. **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code DION RD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces? ò 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. Completed 3 ₩idowed 4 □ Divorced ITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TIC -IAN Be 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 ELMBERRY CT. APT. 1215 onald Hai 10.21122 20b. Place of Disposition (Name of Boernetery, cremary) of attention (Name of Boernetery, cremary) of attention place) 20a. Method of Disposition Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign 22. Name an Address of Facility MIGIN Part 1. Enter the disease, shock, or heart failure. Lis ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 Probably 4 Unknown 1 Yes 2 No been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed 2 No 1 Yes 25. Was case referred to media examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) After thi 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Accident work? 2 \square No Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a ertifier 29d. Date signed (Month, Day, Year,

State

me and add

DHMH 17 Rev 7/2009

Registrar

(Item 23a) (Type, Print)

noleted cause of death

32. Registrar

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Flease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Thomas Milton Haythorn Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) OH 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 □**x**M 2 □ F 218-24-8385 Oct^D1/2: 1929 Director 81 Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Allegany Ellerslie 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14004 South Gardner St. 21529 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 If Yes, Give Completed by Black, White, etc. 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Korea 3 Divorced Specify: white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) electrician & training instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Irene (Bickerton) Haythorn William M. Haythorn 19a. Informant's Name/Relationship (Type, Print) Helen Haythorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14004 South Gardner St. Ellerslie Department of Health ar Important: If item 27 is any injury or other trauonce. MD 21529 wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Restlawn Wemorial Gardens MD LaVale 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name an Scarpelli Führeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pa 11. Enter the dis as or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ hronds Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Completed by Physician/Medical Examine Due to (or as a consequence on. ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed al director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Vos. 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 21 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 SER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🖳 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c. License number Hame and address of person who completed cau 31. Date filed (Month, Day, Year, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 16^{Day} 20[°]ΰ1 05:40 AM Betty Virginia Hammond Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign North East Mary Land Funeral 1 □ M 2 💢F Months Days Hours Min May 13, 1932 78 Director 213-30-7531 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c City Town or Location notified at 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral United States 21901 503 Elk River Manor within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify White If Yes, Give Year or Dates Completed 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Laundry and Housekeeping Hospital 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ಲ Elizabeth Laird permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is market any injury or other traumatic eones. Elmer L. Parrett traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 Loopard Marvland 20685 19a. Informant's Name/Relationship (Type, Print) 115 Chesley Court, St. Leonard, Maryland Betty Smith / Daughter 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Ap 201122, 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Newark, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 21. Signatur Fune Service 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit and Due to (or as a consequence of): resulting in death) Last the burial physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death the g Unknown Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 Unknown Carries 24b. Were autopsy findings available prior to completion of cause of death? COPD 24a. Was an Jas autopsy performed? After this certificate within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending **■** Matural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ind title of certifier 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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KUMA

71040

ite 4105 RALTEMURB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 10 Day 2011 Year 11:36АМ м Eugene Hicks Ha11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1/31/1920 91 Míssouri Director 515-12-0939 Usual Residence of Decedent at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Anne Arundel Annapolis 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1007 Jigger Court 21401 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, "natural", or iter idical Examiner Armed Forces? Black. White, etc. Completed by 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Federal Government Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Car1 Austin Hall Mellie Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois June Hall/Wife 1007 Jigger Court, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2 Cremation 3 Removal from State 4 Donaid 5 Other (Specify) Kalas Crematory 4/12/2011 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21401 P 1 1. Enter the disease, r complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 2 🗆 No 9 Unknown 9 Hlnknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 page performed? Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 🗆 🗡 1
Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending nours after death.

neral Director: After the furth of th 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30. Name and add who completed eause of death (Item 23a) 31. Date filed (Month State

Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alvin T. Heilman Apri] 09 2011 Medical 4:43 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 307 Fernwood Drive Severna Park Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 85 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 26,1925 **Funeral** 9. Birthplace (State or Foreign 357-16-9268 1 🛛 M 2 🗆 F Indiana Director Usual Residence of Decedent a or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 307 Fernwood Drive 21146 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 19
If Yes, Give 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1943 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Completed 3 Widowed 4 ☐ Divorced White 1945 Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edwin Heilman Hazel Heath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Twilley/ Daughter 385 Broadleaf Court Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April Da 1 Burial 2 Cremation 3 Removal cemetery, crematory or other place) Other (Specify) Metro Crematory, INC. Baltimore, MD 2011 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 Signature of Funeral Service Lic 22 . Part Enter the disease, shock or heart failure. Lis lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be cause on each line. Immediat Cause (Final Onset and Death
2 month Physician/ CANCER ANCREATIC disease condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or illiquiy that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No Director: After this certificate has been signed by the d in by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, DIABETES TYPE 11 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown REMOTE HISTORY OF COLON CHNCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ြု 1 🗆 Yes 2 🕡 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direc 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 234) (Type, Print) ROBINSON ROAD SEVERNA PARK, MN 21146 mo 31

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 2 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Month 6:50P Bronwen Hubbard Marv April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 312 Hamlet Circle Edgewater Anne Arundel Social Security Number 8. Date of Birth (Month, Day, July 8, **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 👿 F Wales 89 **Director** 521-38-5827 Usual Residence of Decedent 28a-f shov with the Maryland te 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits iral", or items 23a or 28a-f sh Examiner must be notified a 1 🗌 Yes 2 💢 No Anne Arundel Edgewater Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 USA 312 Hamlet Circle Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Department Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve Lewis John Watkins Ethel Emma Sheppard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis M. Hubbard/Son 11850 Lexington Drive, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 ី Cremation 3 🗔 Removal from State 4-10-2011 4 Donation 5 Other (Specify) Kalas Crematory Edgewater, Maryland 21. Signature Funer I Sen 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical s a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown signed by the a I be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician: in 24 hours after death.

the Funeral Director; After this certific apleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I Medical 29a Certifier Eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2311 MS 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 100 Annapais MD

State

Registrar

31. Date filed (Mo

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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 Year APRTL. FERRELL JOHNSON. 5:51 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Elkton Cecil Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Delaware **Funeral** 8. Date of Birth 1 ★ M 2 □ F Months Days Hours Min. NOV. 28 1948 **Director** 217-50-3526 62 Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DE Kent Smyrna 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 382 Shorty Lane 19977 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Lineworker 12 Automobile Manufacturer is marked other 27 is marked other r traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Calvin Johnson Virginia Dare Bare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr James F. Johnson, Jr. <u>382 Shorty Lane</u> (son) Smyrna, DE 19977 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Odd Fellows Cemetery | 4/14/11 Smyrna, DE. 21. Signature of Funeral So io icense ²². Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Part 1. En shock, or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASYSTR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PIBRILLATION NTV21CU Sequentially list conditions, Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit V200NAV2 Due to (or as a consequence of): resulting in death) Last been signed by the attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ be detached for in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by emphysema 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Director: After this certificate has 1 Yes 2 No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\mathbb{X} \) No Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral I Medical 29a Certifier Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the Last of my kin, who go death contend of this time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D5831 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ms UTWEA 106 ELKTON MID 21921 BOW ST. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Johnson

James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9915 5-6-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Algie Johnson 2011 1131 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arunde1 Annapolis Anne Anne Arundel Medical Center Social Security Number 219 214-38-028 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F Hours Mar 24 Year 939 Maryland **Director** -38-0287 72 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21401 USA 12 N Homeland Ave 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: **Black** 3 Divorced 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. College (1-4 or 5+) Northrop Grumman Quality Control Analyst 2yrs 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frankie L. Terrel Isaac L. Johnson Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21401 12 N Homeland Ave Rosilyn R. Johnson(Wife) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Bases Deposition (Name of cemeter). erematory or other j 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Memorial Park 4-16-11 Annapolis, Md. 4 Donation 5 Other (Specify) WindsmeaRaceses Facilities Sons Mortuary, F.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as gardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes ☐ Pregnam
☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be the funeral director, 26. Place of Death (Check only one) Hospital: 2 🖵 No Other: မ 1 🗌 Yes 1 🗂 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature an 29c. License numbe Month, Day, Year) 20 completed cause of death (Item 23a) (Type, Print) 30. Name and 1111 APR 1 4 2011 31. Date filed (Moi 32. egistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 10,^{Day}011 Mary Grady Kennedy 2051 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 🔽 F 0572871939 Baltimore, MD 71 212-40-5217 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Anne Arundel Crofton 1 ☐ Yes 2 X No 10e. Street and Number 10f, Zip Code 10a, Citizen of What Country? Funeral 1828 Crofton Parkway 21114 USA should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married 2 Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic 6 Hartnett <u>Harry J. Grady</u> nne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Kennedy Son 2311 Manumet Court Crofton,MD 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory or other place) 04/12/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature - Furreral Service Licensee 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Hardesty Funeral Home P.A. aly 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown þ s been signed b should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b I director, page 2 sh autopsy performed 1 ☐ Yes 2 ☐ No After this certificate I Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural work? 5 Pending death. 1 \square Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29c. License number 29b. Signature and title 1 (

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Registrar

30. Name and

31. Date filed (Monta PR 1 2 2011

on who completed cause of death (Item 23a) (Type, P

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #10e per FD AACO Health Dept. A-14-11 KAH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anita J. Klakring April 2011 P^{M} 9:27 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 938 Ships Bell Court Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 1 F 111711741931 79 MaryTand **Director** 218-26-8265 or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 938 Ships 938 Ships Pell Court Funeral 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 □XWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harold Ravenscroft Anna Hartmann 19a. Informant's Name/Relationship (Type, Print)
Carolyn Sears - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8216 Crab Apple Court, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Baltimore Crematory 1 Burial 2 X Cremation 3 Removal from State 4/14/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Mydlin T. Wloka 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ na Iti disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 2 No 1 ☐ Yes 2 L 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 줊 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 autopsy performed? Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after d e Funeral Direct determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completed within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deputy 29d. Date signed (Month, Day, Year) ne and address of person who completed cause of death (Item 23a) (Type, Print) JONES/m 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April ^{Day} 2011 Physician/ Marieta Koufou 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Cooperfield Ct. Phoenix . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) NOV. 9. 1914 1 M 2 XF 96 Yrs. 212-82-2397 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Phoenix MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21131 Greece 1 Cooperfield Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes : If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 1 and 2 should be filed with Health and Mental Hygitem 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kyriaki Louka Costa Kostiou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Cooperfield Ct., Phoenix, MD Sunday Papaminas / Daughter other t permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/9/2011 4 Donation 5 Other (Specify)

21. Signature of Funeral Services icensee Greek Orthodox Cem. Woodlawn, MD 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renal failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Delydration/maluutrition Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Loss of appetite as the burial-transit death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🕱 No Pregnant at time of death Unknown The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24a. Was an performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, is To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

6:54

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Retween

days

week

Year

2 weeks

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

29d. Date signed (Month, Day, Year) April 8, 2011

1 ☐ Yes 2 No

Baltimore

Country)

Greece

Black, White, etc.

РМ

State Registrar

Luthewille, Mayland 21093 Dr. Peter Beltos 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 1 2011

Clet MO

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Falls

DHMH 17 Rev 7/2009

29b. Signatur

10755

D0034193

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Labbe Rene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC g. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 □ M 2 □ F Nov 10. **Director** 002-20-0448 80 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Rawlings MD Allegany 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 16622 North Conda Way 21557 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: 1950-1954 white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Westvaco instrument technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Yvonne M. (Berube) Labbe Rene D. Labbe, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 16622 North Conda Way Rawlings M 19a. Informant's Name/Relationship (Type, Print) MD 21557 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Freda Labbe wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Restlawn Memorial Gardens 4/26/201 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) Sign Jure f Funeral Ser ice Licensee 22. Name and Address II Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Acute Physician/ Cerebrovascular accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner quantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 2 No 1 Yes 2 g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aspiration preumonia After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chrinic Kidney Disease director, page 2 autopsy performe Ischemic Cardianyo path. 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) မ 1

Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1-Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-22-11 le cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 925 SETON DRIVE CUMBERLAND, MD 21 MAGNONI Date filed (Month, Day, Year)
APR 29 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Year 12, AUDREY JOSEPHINE LASATER APRIL 9:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KENT WORTON 24345 SMITHVILLE ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Days 1 □ M 2**X** F Hours Min. JULY 6, Months **Director** 1928 MARYLAND 82 213-24-1353 Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location be notified at Director 1 Yes 2 No MD KENT WORTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a the Medical Examiner must UNITED STATES 24345 SMITHVILLE ROAD 21678 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 XNo and Mental Hygiene. Is marked other than "natural", If Yes Give Specify 3 Widowed 4X Divorced Completed WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) filed within tal Hygiene. SALES CLERK RETAIL 11 Be Jall ...

Jall 2 should be file.

Jepartment of Health and Mental Hu Important: If item 27 is marriany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MILDRED WHEAT WALTER RODNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24345 SMITHVILLE ROAD WORTON, MARYLAND 21678 BONNIE TABOR / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PAUL'S CEMETERY 04/16/2011 CHESTERTOWN, MARYLAND Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Kick of 2/2 HOME 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between menti Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ardiovascular Disease trterro scalutio Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical β use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown ned by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be u 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 \(\sum \) Nursing Home \(\sum \) Residence \(6 \sum \) Other (Specify, 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1- Natural 5 \square Pending 2 🗌 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined filled in t Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

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within 2 To the

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

State Registrar only one)

29b. Signature and title of certifier

Name and address of person

31. Date filed (Month, Day, Year APR 13 2011

32. Redistrar's Signature barto

Whoncompleted cause of death (Item 23a) Type,

Ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day,

(2-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 4 15 Day **Physician** 2011 10:40 pm Aleen Merican /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 91 058-14-1980 29 1919 Director PΑ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No Frostburg Allegany MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 U.S.A. 59 Tarn Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Belle Winebrenner Youngerman Milton Youngerman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20485 Deerwood Park Drive Leonardtown MD 20650 Michael Merican Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4-19-2011 * 4 □ Donation 5 □ Other (Specify) Frostburg Mem Park Frostburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. 60 W. Main Street Frostburg, MD 21532 MO0 5717 Sower Alan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) thore Foilure **Physician** /Medical Due to (or as a consequence of) VA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 2- No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, by the a been signed by should be detact has page this certificate To the Hospital or Attending Physician: ector. funeral di After To the Funeral Director: in by

with the Maryland

death

rel', or items 23a or 28a-f ehow Examiner runt be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or ite any injury or other traumatic event, the Medical Experimen

once.

Examiner

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) APR 2 9 2011 State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

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cal

Medi

Non (idewode 32. Registar's Sign

Valu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Suffer

29c. License number

29d. Date signed (Month, Dey, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1 9 201 1 April 2:50A M IVAN L. MAYES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 2 Mang, Pay, 993 5 215-32-7860 76 **Director** Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b, County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Harford Street MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21154 2870 Dublin Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ White If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 √ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Elsie Arbula Tibbet ည Laban Cletus Mayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
214 Craigtown Road, Port Deposit, MD 21904 Dee Mayes/Daugh-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 1 Burial 2 Cremation 3 Removal from State Bel Air Mem. Gdns. 4/22/2011 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of John Al Service Li Anser 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Kovert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE END disease or condition Medical resulting in death) Examiner CORON ANY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): RENAU INSUKFILLEN nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): HIPBLIEN SION Physician/Medical as 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No
9 ☐ Unknown Year Month Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ HPOTH PUIDISM 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of ANEMIA 24a. Was an cate has page 2 s autopsy performe death? certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDCA funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours are death

To the Funeral Director;

completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 8 who completed cause of death (Item 23a) (Type, Print) 7 Old Emmodon Rd. Suite 220 Bel

State Registrar APR 29 2011

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ary	7 is mar		19a. Informant's Name/Relationship (19b. Mailin	g Address (Stre	et and Number or R		er. Citv or	Town, State, Z	ip Code)		
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Ball	Department of Important: If ite any injury or ot once.		21. Signature of Funeral Service Licer	901	2							Home, P.A.		
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	nding use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of <u>pr</u> egnal	ncy					23d. Date of de	allyon		
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rds equir	bould	etec	1-2-12-612	8111	-							Probably 4 🖾 Unknown		
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DIVISION OF tal or Attending Ph	ath. r: Afte e fune	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Day	(Year)	injury	wo	ork? Yes 2 No	Zod. Describe	now mjur	y occurred			
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	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	alC							City or Tov					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 12, Day 2011 Year Bonnie Joyce Mangini 1437 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Texas **Funeral** 1 🗆 M 2 🗶 I Hours 1172671954 222-42-3776 Director 56 Yrs Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Directo Harford Abingdon MD 1 Yes 2X No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3703 Fenny Lane, Apt. F 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 X Yes 2 No If Yes, Give 975-1977 Year or Dates. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced |くらハハヒ サルス | ||| Baltimore, Maryland 21215-0 other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Assistant Manager Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald R. ByRoade Joyce Jarman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
132 Woodlawn Avenue, Newark, DE 19711 Danny E. Salter Sr./Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State United Crematory or other place) Services 1 Burial 2 X Cremation 3 Removal from State 04/18/2011 Newark, DE 4 Donation 5 Other (Specify) . Signature of Paneral Service Licens 22. Name and Address of Facility Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Examiner 2 Abdom. Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical -ACTIL IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

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9 Unknown Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 힏 Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kapi Kumar Patel 5 21015 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death April Physician/ 2011 John T. Maloney sr 7:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bowie Bowie Health Care Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex 1 M M 2 □ F **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Yrs. 57.7-58-5122 67 1943 Virginia **Director** Aug. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1X Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2702 Baldwin Lane 20715 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces 2 1 Yes 2 ANO If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 P of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Communications Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Joseph Maloney Lillian Connors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna C. Maloney/ Wife 2702 Baldwin Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bactamarary Washington 4/13/2011 20a. Method of Disposition permit. Page 1 Department of I Important: If it any injury or of 1 ☐ Burlal 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee the fitee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of Examiner Cardiomyopathy Sequentially list conditions, cause. Enter Underlying Diabetes Mellitus Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1. Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work' Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 4/7/2011 D0042603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowie Health Care Center, Bowie, MD <u> Hassan Farhat, M.D.</u> 31. Date filed (Month Year, 32. Registrar's Signature State APR 1 2 2011 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April1 089 201°f 11:30 Lawrence Schuyler McLean Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Hours 1 X M 2 D F 0972471925 Washington,D.C Director 85 579-24-0625 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Annapolis Maryland Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 823 Coxswain Way 21401 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No "natural", Specify Specify: White Completed 3 Widowed 4 Divorced 1944-46 Year or Dates. of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Firefighter District of Columbia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Mary Margret Harding William Lawrence McLean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Coxswain Way, Annapolis, Maryland 21401 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Una Mae McLean/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 04/12/2011 Kalas Crematory Edgewater, Maryland 21. Signature of Figure 1 Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Neuvodegenerative disease disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tes မ 24 hours after death.

Funeral Director; After this cleted filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending w<u>or</u>k Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, Maryland Medical Parkway. Stuart Selonick, MO 2003 31. Date filed (Month, State

DHMH 17 Rev 7/2009

Registrar

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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		1		e(Mother)			Address (Street								ocus)
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Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physiciated filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	inad 28e. Place o	of Injury - At g, etc. (Spe	: home, farn	n, street	, factory, office	е		28f	Location (Street ar	nd Numbe e)	r or Rura	l Route Number,
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Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 a	Medical	(Check 2	1 Medical E	xaminer: On the basis Nurse Practioner: To	of examina	tion and/or	investiga	ation, in my opi	nion, d	death occurre	ed at the	time date:	and place	e and due	to the ca	use(s) and manner stated
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State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtI,27,28a-fper me,g920,10/21/2011dhb
Certificate of Death
Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1526 M wens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth une 23 Year) 940 Min. 1 X M 2 - F Maryland 70 **Director** 213-36-3408 Usual Residence of Decedent 28a-f shov 10a, State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Lothian 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 927 Bayard Rd. 20711 item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married þ ☐ Yes 2 🌠 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Body & Fender is marked other than Elementary/Seconday (0-12) uld be filed within it Mental Hygiene. College (1-4 or 5+) 11th Technician 0 Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louise E. Forrester Hillary Owens Sr should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Md. 20711 Violet O. Owens(Wife) 927 Bayard Rd. Lothian, Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Adams U.M. Church : 4 ☐ Donation 5 ☐ Other (Specify) 4-12-11 Lothian, Md. Mmame Reagase of RecilitSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Duna disease or condition resulting in death) Medical quence of Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami and I-transit death certificate be executed ROVED BY HEDICAL EX attending physician a for use as the burial Physician/Medical Box 68760 CERTIFICATION AS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death ed by the a 9 Unknown P.O. signed b **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nes, Jas autopsy nerformed? death? on certificate 2 🗌 No Yes To Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) 1 Ses 2 □ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred **Brachiocephalic**artery injury during insection
porta-cath Certificate: 28b. Time of 28c. Injury at To the Hospital or Attending within 24 hours after death. To the Funeral Director, After Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 04/06/2011 12:35 p^M 1 Yes 2 X No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2001 Medical Parkway, Annapolis, MD 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check opin...
ed at the tim...
License number Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and magner as stated. 29b. Signature and title of 29d. Date signed (Month) Day, Year) eted cause of death (Item 23a) (Type, Print WD DN Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ 105 AM 2019 Kenneth H. Plotts Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 7. Age (In yrs. la 82 Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** txtxt M 2 □ F Months Hours 8/28/1928 302-24-1804 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes**xxx**No Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7959 Telegraph RD. L-147 21144 USA should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes XX No Black, White, etc. 1 Never Married XX Married Completed by Maryland 21215-0036 ☐ Yes 🔀 🗙 No White If Yes, Give 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Superintendent Heavy Equipment Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ္ injury or other traumatic Harold Plotts <u>Leola Moore</u> permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl PLOTTS, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Plotts Wife Telegraph Rd, L-147 Severn, MD 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillcrest Memorial 4/13/2011 Annapolis, MD 21. Signature of Funeral Service Censee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 851 Annapolis RD. Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final set and Death Physician/ MMONIA disease or condition Medical resulting in death) Due to far as a consequence of Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗆 Yes မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred V Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in his opinion, scaling order to be desired at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed gause of death (Item 23a) Type, Print) 31. Date filed (Month, Day, Year) State APR 1 2 201 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	State Registrar	_				ertificate o				leg. No. 🤈	0	13896
Physicia Medic		1. Decedent's Name (First,	Pa+	ch						2. Date of Deat Month	Day Day	Year 1	3. Time of Death
Examin	er	4a. Facility Name (if not inst	itution, give st	reet and numi	ber)	ente	4b. City, Town	or Location		•	4c. Co	unty of Deat	h .
Funeral Director		5. Social Security Number 470–24–3335	6. Sex		7. Age (In yrs. Ia		/) If Under 1 Ye	ar If Und	ler 24 Hrs.	8. Date of Birth 2 (Month 192)	Year)		hplace (State or Foreign untry) MN
Maryland :8a-f show tified at	Funeral Director	Usual Residence of Deceder 10a. State 10b. C MD Ann	_	nde1	10c. City	y, Town or	Location Odenton						10d. Inside City Limits
th the 3a or 2 t be no	ral Di	10e. Street and Number					10f. Zip Cod		2		10g. Citizen	of What Co	untry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	527 Saltoun 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Div	Married 1	A see and Fast	2 □ No 19.	52-	3. Was Decedent of If Yes, specify C	uban, Mexic	Origin? (Spec can, Puerto F	cify Yes or No- Rican, etc.)		Black, White	nican Indian, e, etc. White
in 72 hours e. nan "natura Medical E	Completed	15. D	ecedent's Edu / highest grad	cation		16a. Dec	cedent's Usual Oc ve kind of work do DO NOT use retir	ne` <i>during m</i> ed)	ost of workin	ng	16b. Kind	of Business	Industry
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Page 1 a ment of H ant: If ite ury or ot		20a. Method of Disposition 1 XXBurial 2 ☐ Cren 4 ☐ Donation 5 ☐ C			State	emetery, c. Lingt	position (Name of rematory or other on Natio	na1		ate UNK	Arli	ngton	
permit. Depart Import any inj once.		21. Signature of Funeral Se	Ce Licensee	-			22. Name and Ad 851 Anna			esty Fu Gambril			
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Medical Examiner		resulting in death)		Due to (or as a consequ	ence of):							
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To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total states.	Physician/Medi	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	IL.	1 Live E	come of pregna Birth 2 Feta nant at time of c own	al death 3	B				23d	. Date of del Month	ivery Day Year
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To 1 To t		29b. Signature and title of o	ertifier		00 -		29c. Lice	ense numbe	er		2.0	gned (Month	
111	1	30. Name and address of p	erson who co	mpleted cause	e of death (Item	23a) (Type	Print) ene St.	981	VI - 0 - 1			5,20	111
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene For State Registrar 389 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen Joseph Remicci April 21, 2011 2011 12:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15500 Winslow Street Cumberland, MD Allegany Social Security Number 6. Sex 1 ☐ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 212-78-4833 Min. Hours Mar. 4, 1957 54 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 🗆 Yes 2 🎽 No 10e. Street and Number 10f. Zip Code 21502 10g. Citizen of What Country?
U.S.A. Funeral 15500 Winslow Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
None College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sebastian Remicci Patricia (Childrey) Remicci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Wines Guardian 367 Pear St., Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Scarpelli Crematory Apr. 22, 11 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service any in once. 22. Name and Address of Facility Hafer Funeral Service, PA 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition O Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate caus. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No ☐ Yes 2 within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 W Other (Specify) 9 COUP home Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 006643 4/21/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLANCHE MAYROMATIS 12 SeZ WILLOW SUITE 300 12502 WILLOW BROOK RD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

28

32. Registrar's Signature

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9036	s after dea al", or itel Examiner	by	11. Marital Status 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🛣 No lif Yes, Give Year or Dates.		Yes 2 X No		pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc. Nhite
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Baltimore,	Page 1 an nent of He ant: If iten ıry or othe		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	Db. Place of Dispo cemetery, cren Baltimore	sition (Name of natory or other pla Crema Co	ory 4/1	Date 2/2011	20c. Location - City Baltimore	or Town, State , Maryland
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. Box 68760	Hospital or Attenting Physician: The law requires that the death certificate be 24 hours after death. Purple of the consistent death this certificate has been signed by the attending physiciated filled in by the funeral director, page 2 should be detached for use as the but the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pro 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date of Month	delivery Day Year
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	7		Name and address of person who come to the common of the c	e FanAm	(Item 23a) (Type, P	DEYENS	E Hwy/	ANNAR	Kr) Mnz	1401
	Stat Registra	e ir	31. Date filed (Month, Day, Year) APR 1320	32. Registrar's Si	gnature A.	harles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Philip Physician/ Richebourg April 10 2011 4:48 AMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7101 Bay Front Drive #612 Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 548-26-8055 Days 1 🔀 M 2 🗆 F 91 Months Hours Min 9/19/1919 Director California Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis Yes 2 No 7101 Bay Front Drive 10f. Zip Code 10g. Citizen of What Country? 21403 Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 Yes 2XXNo Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1941-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Broker Real Estate/Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Richebourg Sarah D. Abell 19a. Informant's Name/Relationship (Type, Print) (daughter) Elizabeth Richebourg Rea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 W. Church Hill Road Washington, CT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 4/11/2011 |Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of uneral/Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Annapolis, MD 21401 147 Duke of Gloucester St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Congestiv disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (o, as a consequence of) Exami death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Yes P.0. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2\No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perforn Division of Vital the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DO05294 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ramona Seidel 269 Peninsula Farm Road, Suite F, Arnold, Maryland

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Da

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			For State Registrar	State of Ma	rylan			ent of F te of E			Reg. No	1100	13900	
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	Examin	er	4a. Facility Name (if not institution, give						Location of Death					
	Funeral		Doctor's Communit 5. Social Security Number 6. S	ex 7. Age	(In yrs. la	ıst birthday)		der 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Bi	irthplace (State or Foreign	
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Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ted by	1 Never Married 2 🕅 Married 3 🗌 Widowed 4 🗌 Divorced	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates.	51- 53	1	☐ Yes	2 💢 No	Specify:			Specify: Wh	ite	
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yla	uld be I Ment narke natic	욘	Hugh E. Robey						Maria L					
Mai	2 shouth and the and the and the and the traum	73	19a. Informant's Name/Relationship (7) Helen E. Robey/ V	,, ,		1	_							
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_	S G. B	<u></u>	resulting in death) Last	Due to (or as a	consequ	ence of):								
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Box 68760	eath certificate be attending physic d for use as the bi	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	☐ Fetal	I death 3 🗌		c pregnanc	ry				*	
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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director.	Medical	(Check 2 Medical Exam	iner: On the basis of exa	mination	and/or investi	igation, i	in my opinio	on, death occurred a	at the time, date	and place	e, and due to the	e cause(s) and manner stated.	
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11-02949 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John David Stringfellow State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 18, 2011 John David Stringfellow **Medical Examiner** 1640 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 213-15-4487 Director Months Davs Hours Min 38 1 X M 2 F Nov. 22, 1972 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 Yes 2 No Greenbelt 28a-f shov vermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "autural", or items 23a or 28a-f she ajury or other traumatic event, the Medical Esaminer must be notified as once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 28a-notified at 1B Woodlan Way 20770 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes 1 Yes 2 No specify: 4 X Divorced If Yes, Give Year White Specify: ੬ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1-4 State Trooper Maryland 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Frank Stringfellow Therese Madden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Stringfellow -father 1B Woodlan Way Greenbelt, Maryland 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State 4/22/2011 Silver Spring, Maryland 4 Donation 5 Other Specify: 22 Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service License PA Maryland 20705 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of); Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical g physician a UNPENDED AMENDED Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? attending or use as ti Day Live birth 3 Ectopic pregnancy Month Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital examiner* Other Nursing Home 5 Residence 6 Other After this 1 V Yes 2 No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject jumped off bridge Natural FOUND: 1 Yes 2 ✔ No Director: In by the f Pending Apr 18, 2011 2 Accident 1600 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 V Suicide Could not be or Town, State) W/B Bay Bridge, Anne Arundel County, MD determined (Specify) Bay Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

10

State 31. Date filed.(Month, Day, Year)
Registrar

Carol Allan, MD

00

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 19, 2011

30. Name and address of person who completed cause of death (Item 23a)

Cecil Amend	CO-He	ea #2	lth Dept- 5-5	-v∂lea	se Type o	Print in	Black Ir	ndelible	e Ink	. Ens	ure A	Il Copie	s Are	e Legibl	e.	
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036 rs after death	ral", or item: Examiner m	ا ۾	11. Marital Status 1 X Never Married 3 □ Widowed 4 [Armed F	2 □ No ve	ŀ	Vas Decede f Yes, specif	fy Cubai	n, Mexican	, Puerto	cify Yes or No- Rican, etc.)	-	14. Race - Ai Black, W Specify: V	hite, et	o
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, Mar y nd 2 shoul	ealth and I		19a. Informant's Name/Relationship (Type, Print) Ann Schreder / Sister in Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Glendale Drive, Lancaster, PA 17602													
Baltimore,	ment of H tant: If ite		20a. Method of Dispos 1 X Burial 2 ☐ 4 ☐ Donation 5	Cremation		n State		h New	her place Cat	th Ce	m. 0		La	ocation - City	c, E	PA
Ball	Department of Important: If any injury or once.		21. Signature of uner	al Service Li	THI JA									uneral , MD 21		ne, P.A.
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Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian death.		IF FEMALE: 23b. Was decedent proving the past 12 mo 1 Yes 2 N 9 Unknown	nths?	1 🗆 Live	utcome of pregnate Birth 2 Defet Fet gnant at time of known	al death 3	Ectopic pr Other (spe		у				23d. Date of Month		y Day Year
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Divisio al or Atter	s after des	l Certificate:		6 Could r determi	ot be 28e. Plac	e of Injury - At h	ome, farm, str	eet, factory,	office			28f. Location (City or To	Street ar wn, State	nd Number or e)	Rural F	oute Number,
le Hospit	in 24 hour he Funera pleted fille	Medical	(Check 2	Medical Ex	Physician: To the caminer: On the ba Nurse Practioner	asis of examination	n and/or invest	tigation, in m	ny opinio	n, death or	ccurred at	the time, date	and plac	e, and due to the	he caus	e(s) and manner stated.
و	Vith Com	_ [29b. Signature and title	e of certifier	ild!	Chel.	7	29c.	License	number	30	7	29d. Da	ate signed (Mo	20	ay, Year)
10+	IVA		30, Name and address	of person w	tho completed cau	se of death (Iter	n 23a) (Type, F	rint)	Qy	A	ve,	ELK	(78.	N, Mi)2	1921
	State Registrar		31. Date filed (Month, I	PR 1	2011 32.	Registrar's Signa	ature	books			7			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2<u>011</u> MARIE MARGARETA PFEFFER STERBACH 10 APRIL 1:25A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death KENT **CHESTERTOWN** CHESTER RIVER MANOR 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min 01/31/1919 Director GERMANY 199-30-6692 92 Usual Residence of Decedent fshow ld be filed within 72 hours after death with the Maryland Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Xyes 2 No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 HADAWAY DRIVE APT. 12 21620 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? 1 Yes 2 No If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Specify: Year or Dates WHITE other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked မ JOHN PFEFFER BARBARA HORN . Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALTER C. STERBACH / SON CEDAR CHIP COURT PARKVILLE, MARYLAND 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 04/11/2011 CHESTER, MARYLAND 21. Sig atur of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause or at caused the death not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer each line Immediate Cause (Final Onset and Death PNEUMO Physician/ disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 1 Yes 2 9 Unknown 2 No signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ ADVANCED DEMENTIA 2 No 3 Probably 4 Unknown Completed 1 Yes is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: , completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

3

29b. Signature and title of certif

DHMH 17 Rev 7/2009

leted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ames 315/ 355-P M 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arunde1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) 1X1X M 2 □ F Months Days Hours Min (Month Day Year) 6/25/1945 213-44-1251 Director 65 MD Usual Residence of Decedent show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City. Town or Location Director 10d. Inside City Limits Anne Arundel Severn 1 Yes XXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1506 King Philip Circle 21144 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Completed by Baltimore, Maryland 21215-0036 Yes 2x X No If Yes, Give Year or Dates nit. Page 1 and 2 should be filed within 72 mou... sartment of Health and Mental Hygiene. 1 ☐ Yes XX No Specify 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service Dispatcher Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Keith Thornton Sisk Edna Daughtrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Sisk Wife 1506 King Philip Circle permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 🎇 Cremation 3 DRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/12/2011 Glen Burnie, MD Signature of Funeral Ser 22. Name and Address of FacilityHardesty, Funeral Home, P.A. 10 Gambrills, MD 21054 Annapolis RD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ Onset and Death 1mD homa disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform 1 Ves 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2. No Other: 1 🗌 Yes မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death.

Director: Aff
in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Day, Year 2011 30. Name and address of on who completed cause of death (Item 23a) (Type, Print) Amapoli MU 5117

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201°1 April 1 07:05 P M Eve Muriel Stepp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arunde1 Examiner 411 Londontown Road Edgewater Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last hirthday 9. Birthplace (State or Foreign Mary Vand 8 Date of Birth **Funeral** 04905911926 85 220-12-2794 Director Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2 🏌 No Maryland Anne Arundel Edgewater 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be by Funeral items 23a 21037 United States 411 Londontown Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ö 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates White Specify. "natural" Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store 8 Cashier Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other transmit. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Oakley Sellars Clara Hazel Conger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Londontown Road, Edgewater, Maryland 21037 John P. Stepp, Jr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 104/12/2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur eral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Interval Betwee Immediate Cause (Final Physician/ disease or condition month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by to the sign of the s Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STENOSIS 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certifice completed filled in by the funeral director, t 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. . Signature and title of certifie 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 07

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2 shou	Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's N	ame/Relationship	(Type. Print)			iling Address (Street				•		
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#	5		30. Name and add	ress of person wh	o completed car	use of death (Item 23a) (Typ	EFENSE	HW	9 AND	VAP OL	15 MD 2	1401	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ FFH 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 314 N. LINDEN AVE ANNE_ARUNDEL ANNAPOLIS 6. Sex 1 M 2 □ F 5. Social Security Number Age (In yrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 12/07/1956 Director PENNSYLVANIA 54 294-58-7465 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified or 28a-f 1 Yes 2 XNo ANNAPOLIS MARYLAND ANNE ARUNDEI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21401 314 N. LINDEN AVE USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. "natural", or 1 Never Married 2 X Married þ 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mel life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DIRECTOR OF SPECIAL PROJECTS NON-PROFIT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည THOMAS SMITH MARGARET MCLANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER G. SMITH/WIFE MD 21401 314 N. LINDEN AVE, ANNAPOLIS, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 04/13/2011 STEVENSVILLE, MD . Signature of Funeral Service Lice 22. Name and Address of Facility HELFENBEIN& P.A. 814 BES Part 1. Enter the disease or complications that caused shock, or heart failure List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician, Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Completed 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ြု 1 🗌 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the less of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. gature and title of ed cause of death (Item 23a) (Type, Pro 0 Name and address of person wh State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jamie Mae Tob	in	1- For State Registrar	State	e of Maryla		epartment <i>Certificate</i>			Mental	Hygiene	Reg. No	201	· Para Taran	13908
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Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		4 Donation 5 21. Signature of Fu	neral Service Lice	nsee					-		1 21	ford Fu	g ,mar neral	Home
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Physician ./Medical		23a. Part I. Enter th failure. List onl	y one cause on e	each line.	aused the d	eath. Do not ent	er the mode	of dying, su	ch as cardiac	or respiratory a	arrest, sh	nock, or heart		ween Onset and Death
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	nine	if any, leading to im cause. Enter Under	rlying Cause	Due to (or as a	consequer	ice of):								
ed sit	Examiner	(Disease or injury the events resulting in contact the		Due to (or es a	consequen	ice of):	-			,		·		<u>-</u>
Division of Vital Records, P.O. Box 68760, the Booking or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED			20b p	er fh g	914.4	-28-11	vt					
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Box 68760, i death certificate be the attending physic of for use as the bur	Physicia	1 Yes 2 N	o 9 🗹 Unknow			5	Other (Sp	ecify)			1984			
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of Vital Records, or Physician: The law requirement of the Configuration	5									1 ✓ Yes	2			2 No
Vital ysician his certi	Be	25. Was case referre		Hospital: 1 tr	patient 2	ER/Outpatie	ent 3		Death (Chec		Resid	lence 6 🗸 Ot	her Scen	9
of V	Ë.	1 ✓ Yes 2 27. Manner of Death	No No	28a. Date of	of Injury	28b. Time		28c. Injury a		28d. Describ	e how in	jury occurred		
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Division tal or Attendiars after death.	Certification:	3 Suicide	6 Could no determine	t be 28e, Place		At home, farm, s		y, office build	ding, etc.	or Town.	State)			ute Number, City
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Divisior To the Hospital or Attent within 24 hours at er death To the Funeral Director: completely filled in by the	Medical	(Check only	CertifyIng Physic Medical Examine		f examinati									e(s)
E > E 8	£	29b. Signature and t	itle of certifier	/ Co	<u></u>		29	ec. License n	umber		29d.	Date signed (Month, Da	y, Year)
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L1	ſ	 Name and addre Carol Allan, 		completed cause ant Medical E			n Street.	Baltimore	, MD 212	 01				
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Regist	rar	APR 28	2011 /	me,	B. A	arke		· · · · · · · · · · · · · · · · · · ·						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ April 8 Robert F. Tripp 2:17 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) 64 yrs. If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Jan. 11, 1947 Massachusetts Hours 029-34-7536 Director Usual Residence of Decedent 28a-f show 10a. State 10h County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified MD Prince George's Bowie Yes 2 No 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 15015 Nighthawk Lane 20716 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give or i Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 1973 th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roy M. Tripp Marion Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 15015 Nighthawk Lane, Bowie, MD 20716 Jeanne M. Tripp / Spouse or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 4/14/2011 Clinton, MD Resurrection Cem. 21. Signature of Funeral Se 22. Name and Address of Facility Beall Funeral Home ervice Licensee 6512 NW Crain Hwy., Bowie, MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. rt 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Due to (or da consequence of): Medical Examiner For Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): OPD and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year Yes 2 No the g Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ bet 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s cm19 autopsy performed? Yes 2 certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Hospital: Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the test of my incoming death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 2 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Gould 2000

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ April 201^{Year} Ellaine 7:05 Mary Vargot Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Hours Min. 06-21-192 Pennsylvania Director 190-20-2749 83 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8405 Garland Avenue 20903 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: 3 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) 4 School Teacher Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0tt Evelvn DeLong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9253 Blue Sky Court, Owings, Mathieu D. Vargot, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 04-18-11 Alexandria. VA Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicianz disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 fyes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year the i ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed' Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No မှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral 1 Natural work? 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practionen To the best of my knowledge 29b. Signature and title of certifier

dres 10

State: Registrar 30. Name and address of person who comp

APR 1R

Harshinge 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

HUSPITAL

eted cause of death (Item 23a) (Type, Print)

32. Registra Signature

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Prince Trederickims zone

PLAC Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per fh, g916,06/02/2011 and Mental Hygiene for State Registrar 2011 13911 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 16, Day 2011 Samue1 Jacob Worley 6:00 М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Burnett Calvert Hospice House Prince Frederick Calvert Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗙 M 2 🗆 87 09/10/1923 Director 229-18-6145 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if frem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Fyaminar must have also in the American Fyamina to a start of the start of the Medical Fyamina must have also any injury or other traumatic event, the Medical Fyamina must have also any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Calvert Prince Frederick MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20678 5490 Hallowing Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 A Yes 2 No
If Yes, Give 19 Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Year or Dates. 1943–46 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Annie Elizabeth Riffe Philip Allen Worley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn W. Humberd, daughter 7833 C. Street, Chesapeake Beach, MD 20732 20a. Method of Disposition
1 □ Burial 2 ♣ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 04/18/2011 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William R. Gross per DVR 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Failure to Thrive Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \sum No Hospice Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 \(\sum \) Yes 2 \(\sum \) No injury 5 Pending ☐ Accident ☐ Suicide Μ Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying No rse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of 29c. License numbe 29d. Date signed (Month, Pay, Year) 25 D17324 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymon A. Noble, M.D. 238 Merrimac Ct., Prince Frederick, MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 10, 20 17 12:35 p M Ernest N. Wills, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**⊠** M 2 □ F Months Days (Month, Day, Yo March 23 Country Director 89 217-32-2213 Usual Residence of Decedent or 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Calvert Owings 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 1946 Horace Ward Road 20736 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: 3 -Widowed 4 - Divorced Specify: Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ' Elementary/Seconday (0-12)
UNKNOWN College (1-4 or 5+) **Public Schools Bus Driver** Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wesley Wills Mary Susan Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odarise V. Coates - granddaughte 1718 Quarter Ave., Capitol Heights, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carters UM Church Cem. April 18, 2011 4 Donation 5 Other (Specify) Friendship, MD . Signature of Funeral Service Licensee Sewell Funeral Home, P.A. 22. Name and Address of Facility 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician wer wary RTERY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 USe as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) jo in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medica filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Tes 2 - No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25475 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 305 Prince Trederick, MD range 31. Date filed (Month, Day, 32. Registra State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 29 2019 2:27a Samuel Edward Arbuthnot Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Days Mar. 12 1923 216-16-1838 88 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 ☐ Yes 2 🔯 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 21234 USA 2424 Lampost Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Consulting Engineering Mechanical Engineer Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be fill Department of Health and Mentall Important: If item 27 is marked c any injury or other traumatic eve မ Anna Margaret Faulkner Samuel Arbuthnot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2424 Lampost Lane: Baltimore, MD 21234 Joyce L. Arbuthnot wife 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Other (Specify) 4 Donation Dulanev Vallev Mem Gardens 5/2/2011 Timonium. MD 22. Name and Address of Facility 1050 York Road 21. Signature of Fun val Service Leanne Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION ₽hysician/ MYUCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ANTENIOSCLENOTIC CARDIOVASCULAR DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ INTRAVENTRICULAR HEMURRHAGE Completed 1 Yes 2 No 3 Probably 4 □ Unknown CHRUNIC UBSTRUCTIVE LUNG DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death. Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Matural Natural 5 \square Pending work 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) len MD 4/29/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUNAU) T WEG EN 6535 N N, CHARLES ST BALLU MD ZIZUY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 920AM rown 11005 Dori Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHUB 1-ARM MARRIOTTS VILLE Carroll KOAD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ohio 8. Date of Birth **Funeral** 1 ☐ M 2X☐ F Days Months Hours April 18, 1939 275-34-9697 71 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Stark Canton Ohio 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44708 Funeral 4433 Baunack Avenue, NW Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 🏻 No Specify: Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Developement Center Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John W.English Dorothy E. Mospens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4433 Baunack Avenue,NW Canton,Ohio 44708 Richard Brown 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Surfset^{ry}, Hillis Membry Canton, Ohio 4-21-11 4 ☐ Donation 5 ☐ Other (Specify) Gardens 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. . Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peach Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) h Residence 2 🗌 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. who completed cause of death (Item 23a) (Type, Print) erson Jr.MD 2973 Manchester RJ Manchester MD 101 . Henderson Jr. MD State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 15,05/02/2011dnb,30 Mental Hygiene 1 | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ TOANN BARTEE 0017 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days (Month, Day, Year) Feb 10 1945 230-58-2778 Director Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Dayton 1 ☐ Yes 2 🌠 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13975 Howard Road 21036 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) telecommunications telephone operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vickers Tiny White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chance N. Bartee (son) 13975 Howard Rd., Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 4-28-11 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Haus 400764 14 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 1 vo courdin Interetion Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ page 2 should be detached for Day Year Pregnant at time of death g 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 🗹 No Other: ျှ 1 Tyes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) COTT 29b. Signature and title of certifier MD D0470109 APR 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Dr. E. Schabelman

MAY 0 2 2011

31. Date filed (Month, Day, Year)

7

Registrar's Signature

5755 Cedar Ln., Columbia, MD 21044

13916

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BARBARA Month 4:57 PM **Physician** 201 APRI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2X□ F Maryland 18,1944 66 218-40-0113 April Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County orant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Dunda1k 1 ☐ Yes 2x No Director MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22a any Injury or other traumatic axion. United States 21222 Funeral 7829 St. Patricia Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☐No Specify 9 Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine E. Dennis Charles S. Twist, Sr. ၉ 19a. Informant's Name/Relationship (Type. Print) ${\sf Husband}$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7829 St. Patricia Lane Mr. William D. Ballantine, Sr. Dundalk, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland Valley Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) Dulaney 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 art 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death mmediate Cause (Final MYOCARDIAL INFARCTION ACUTE **Physician** hours disease or condition resulting in death) /Medical Unknown Examiner Coronarn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death Live birth 3 Tectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 🗌 No Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 □ No Hospital: Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ 28a. Date of Injury this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after death. I Director: After th 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours Funeral 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and D63533 2011 M.D 30. Name and "ddress of person who completed cause of death (Item 23a) (Type, Print) ROS JEFFREY 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month JENNIE ANGELING BENNETT 3: YO AM 04 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE GOOD SAMARITAN BALTIMORE Birthplace (State or Foreign Country) Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 💢 F MD Director 212-22-1530 Heual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2604 Goodwood Road 21214 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 0 ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Divorced White other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Religious Bookstore 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental H Zita Romano Concetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Page 1 and 2 William Bennett, Husband 2604 Goodwood Road, Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 04/25/2011 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arrythmia Cardiac disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hours Hyperkalemio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hip Hemiauthroplasty, Hyperlension 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? Diabetes, Coronau Artery 24a Was an autopsy performed? 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 \(\subseteq \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate 28d. Describe how injury occurred 5 🗍 Pending 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of mm RES 000 4/20/2011 deress of person who completed cause of death (Item 23a) (Type, Print) BLVD, BALTIMORE, MD RAVEN MD 5601 LOCH ZIN

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ap/ 17 27 Day 2011 Year Constance Barron 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c County of Death Baltimore Gilchrist Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 61 222-34-4741 Pennsy Ivania Yrs. Director 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Maryland Baltimore Timonium 1 🗆 Yes 2 🕅 No 10e. Street and Number ō 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 21093 260 E. Padonia Road U.S.A. De filed within.

Jental Hygiene.
Iarked other than "natural", or Its.

"ent, the Medical Examiner my within 72 hours after death Was Deces. Armed Forces? Ves 2 No 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Insurance Broker Insurance Be 17. Father's Name (First, Middle, Last) 18, Mother's Name *(First, Middle, Maiden Surname)* Hazel Gibson and Mental I ပ္ Raymond Eggers permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 E. Padonia Road Timonium, Maryland 21093 Robert Barron, Jr. / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State More land Memorial Park 4/30/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 21. Signature of Fune at Service Line 22. Name and Address of Facility 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 1mh0819 disease or condition 4 cerr Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• La hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and eled filled in by the furnerial director, page 2 should be detached for use as the burial-transit eled filled in by the furnerial director, page 2 should be detached for use as the burial-transit Cause (Disease or imput that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Hospital: 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛰 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 12007063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SNIP 4005 Chances St trongre, MD 2122 aura Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Denartment of Health and Mental Hydiene. Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death Division of Vital Records, P.O. Box 68760

	Registrar				Department of Certificate of			2 (eg. No.)	1392		
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		st Hospi				lstown			1timo			
	5. Social Security N 003-22- Usual Residence o	4530	Sex 1 M 2 □ F	e (In yrs. last bir 79						9. Birthplace (State or Forei Rey, Year) New Hampshire		
ō	10a. State	10b. County		10c. City, Tow	n or Location				10d. Inside City Li			
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	Carol Cl	lifford/f	ormer spou		524 Alfred							
		•	Removal from State		of Disposition (Name of ery, crematory or other pla		Date	20c. Locatio	on - City or	Town, State		
	21. Signature of F	neral Service Lice	mses ade, Dir	ector	State MAR Baltimore			Balti	more	Street		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 405 Medical Facility Name (if not institution, give street and pumber) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** 1 M 2 - F Months Hours Min. Director Yrs Usual Reside 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1. Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working DO NOT use retired) College (1-4 or 5+) To Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 1Ch 19a. Informant's Name/ elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VOUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, cre 4 Donation 5 Other (Specify) 21. Signature TON BOS BUTIME 22. Name and Address 23a. Parv 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Quuse (Final Onset and Death Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 124 hours after death.
Puneral Director. After this certificate has been signed. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 🗌 Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

DHMH 17 Rev 7/2009

Memori

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			For State	State of M	laryland		artment of H		and M	lental Hy	giene		13922
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П	Physicia		Floren	1 0 0	Yne					2. Date of De	Day	Year 20 1	3. Time of Death
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show after integrate in the mastic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 ☐ Never Married 2 ☐ Mar3 ☒ Widowed 4 ☐ Divorced	If You Give	Ever in U.S.	II	Vas Decedent of Hi Yes, specify Cuba	n, Mexican,	jin? (Spec , Puerto f	cify Yes or No- Rican, etc.)	Blac	e - America k, White, e Whit	etc.
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Division of Vital Records,	tal or safte al Dire	27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Natural 28c. Injury at work? 1 Nestigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Roughle City or Town, State)											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the within comp	(Cleck 2 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. Ray apake M.D. 2835 Smilh Av S-203 Baltimore, MD 21209 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year)								Day, Year)			
		DOUS7465 4127/11											
_			30. Name and address of person v	who completed cause of d	eath (Item 2 7835	23a) (Type, Pr 5m1/h	Av S-	203		Ballin	out, N	10 2	1209.
	Stat Registra	-	31. Date filed (Month, Day, Year) MAY 0 2 2011	32. Registra	ar's Signatu	factor	,						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Dorothy Czernikowski 2011 4:06 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Dunda1k 1917 Stanhope Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28, 1929 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 X F Days Hours Months Maryland Director 218-26-4594 81 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 V No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1917 Stanhope Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. . or 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 x Widowed 4 ☐ Divorced "natural", Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Schriefer Evelyn Gladfelter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Karen Czernikowski (Daughter) 6102 Shady Spring Ave. Baltimore, Md. 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 4/30/2011 Baltimore, Maryland Lawn Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 21. Signatur of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of intrathoracic Physician/ MANY negalación disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any leading to cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to or as a consequence of burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Year Pregnant at time of death the 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown dis case page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy performed death? this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director; Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

only one)

31. Date filed (Month, Day, Year,

30. Name and

DHMH 17 Flex 7/2009

To the Within 2 To the

address of person who completed cause of death (Item 23a) (Type, Print)

202 5

32. Registrar's Signature

00001189

11-03174 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Thomas Maguire Carney State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 26, 2011 0810 hrs Medical Examiner Carney Thomas Μ. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County Baltimore** 6451 Cloisters Gate Court If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Country)Maryland Months Days Hours Director June 9. 1986 24 213-21-1082 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. Count E P 1 Yes 2 X No or 28a-f show Baltimore Marvland Baltimore bermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 13a or 28a-f sho niup or other traumatic event, the Medical Examiner must be notified at once. irector 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U.S.A. 21212 6451 Cloister Gate Drive 14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married Yes White 1 Yes 2 X No specify: Specify: 4 Divorced If Yes, Give Year 3 Widowed ğ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) event, the Medical Baltimore, MD 21215-0036 Financial T. Rowe Price Agent 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marla R. Barbary T. Kevin Carney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6451 Cloister Gate Drive. Baltimore, MD 21212 T. Kevin Carney/ Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 04/30/2011 Timonium, Maryland Dulaney Valley Mem. 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service License Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Western Death a. Intra-oral Shotgun Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and S r use as the bree UNPENDED AMENDED ician/Medi Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) director, 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Subject shot self 1 Natural FOUND: 1 Yes 2 ✓ No Pending 24 hours after death. Funeral Director: Director: 0756 hrs Apr 26, 2011 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 6451 Cloisters Gate Court , Baltimore , MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 27, 2011

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State Registrar

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

OCME

Please Type or Print in Black Indelible Ipk, Ensure All Copies Are Legible. amend item 10a per fh g915 5-2-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CABBELL 10-Z0// Physician ARRY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner KENSINGTON NURSING, LLC MONTGOMERY KENSINGTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 67 - 20 - 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2□ F Months Yrs. 578-04-5892 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at WASHINGTON, D. 1 ☐ Yes 2 ☐ No Director DC. 10e. Street and Number 10g. Citizen of What Country? 4974 St. N.E. USA 20019 by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Never Married 2 ☐ Married ☐Yes 2☐No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) Hampton Park Elementary/Secondary (0-12) College (1-4or 5+) maintenance APart MenTS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any liniury or other traumatic evone. Bobbie Rice Abbell JAMes ၀ 19a. Informant's Namo/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 D STrEET N.E. #4, WASH. DC. Abbell MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ID Cremation 3 ☐ Removal from State Date 4/20/21/ Beltsville, MI)
Facility
TUNEVAL HOME WASH. DC., 20002 hesafeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Squamous Cell Carcinoma Immediate Cause (Final disease or condition resulting in death) Advanced **Physician** Unknown /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Dav Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No the 9 Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Deep Vein thromhosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐Yes 2 ☐ No 2 No 1 ☐ Yes **Division of Vital** Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number howay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burtonsville, MD 20866 OWDIAURY, MD; 15216 32. Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23b, 26 per doc g915 5-2-11 yt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03:42 PM April 2011 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE EMERITUS OF PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Hours 219-18-7320 **Director** 87 OCT 31.1923 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director MD BALTIMORE BALTIMORE 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3004 OLD COURT ROAD 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 **XX** Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ KIRSSIN **HENRY** MORSTEIN LYDIA 19a. Informant's Name/Relationship (Type, Print)
LAURENCE CARTON/SON Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3004 OLD COURT RD; BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ARLINGTON CHIZUK AMUNO 4/29/2011 BALTIMORE, MD Funeral S vice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signa 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Hypertension Sequentially list conditions. Examine Lary, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for es a consecuence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and commissed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician. The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? assisted living 2 🖪 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 3 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 201 H68214 0.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Berger

Pate filed (Month, Day, Year) AY 0 2 2011 2700 Quarry Lake Drive Suite 280 Baltimore, MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 State JamaGland 6 De3 artment Jf Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:10A M Patrick James Dempsey Apri 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick Social Security Number 9. Birthplace (State or Foreign Country) Connecticut 7. Age (In vrs. last birthday If Under 24 Hrs. 8 Date of Birth **Funeral** 1 X M 2 🗆 F Days Hours (Month, Day, Year) 12/05/1934 **Director** 044-26-4377 76 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Poolesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16906 Hughes Road 20837 U.S.A. filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed + Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cartographer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o . Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o James Demosev Mary Cecelia Heneghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16906 Hughes Road, Poolesville, MD 20837 Patricia Monday / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o once, cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 04/27/2011 Hanover, Maryland 21. Signature of uneral Service License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a, Part 1, Enter the disea complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him edite cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No 2 No 1 🗌 Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ျှ 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 1 Yes 2 🗆 No Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifiei (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and addres

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink Fnsure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death ARBAN Dav Physician/ Month 2:50 PM APRIL 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWE HOSP RANDALISTOWN IMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days June 24,1957 1 K M 2 D F MaryTand Director 217-60-7260 53 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director must be notified 1 Yes 2x No MD Ellicott City Howard 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21043 8104 Highmeadow Court 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by "natural", or 1 Never Married 2 X Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced B1ack Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) IT Specialist Northrop Grumman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Denola Beagle Claude William Dargan , II item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Dargan (Wife) 8104 Highmeadow Court Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial May 5, 2011 Elkridge, Maryland 20a. Method of Disposition Department of H Important: If ite any injury or ott once. 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman, Funeral Home, Inc 7250 Washington Blvd., £1kridge, Maryland, 21075 W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death DISEASE Ph_sician/ ATHEROSCUEROTIC CARDIONASCULAR disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine in any, leading to minediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 🗆 No signed by the a Id be detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat/? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autonsy death? 2 1 No Yes 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No ျှ 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 24 hours after death. Funeral Director; At 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Sionatu APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILLATEL 5401 COURT 2/133 ROTHUN 000 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1,2 per doc, 16b per fh 2915 5-2-11 vs State of Maryland / Department of Health and Mental Hygien | 13929 State Registrar Certificate of Death Reg. No 2011 Decedent's Name (First, Middle, Last) **Gilberte** 2. Date of Death Darmon 3. Time of Death Esther Month, Physician/ 81 YOR Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Center St. Mary's Count MARY'S NUISING LEONARDTOWN 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) ALGERIA (Month Day, Months Hours Min. 1 🗆 M 2 🔀 84 6040 Director s 23a or 28a-f show ust be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No BALTIMORE OWINGS MILLS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9741 REESE FARM ROAD 21117 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: WHITE "natural" Completed 3 Widowed 4 Divorced Il Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **EDUCATION** College (1-4 or 5+) Elementary/Seconday (0-12) TEACHER **EDUATION** other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked o traumatic eve 2 CHOUKROUN ETOILLE EMIL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 23410 CLIFFORD COURT, HOLLYWOOD, MD 20636 MICHELE LEIKACH / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 04/29/2011 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mondell 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. 23a, Part 1. Enter the disease, or complic Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner DOVOTORU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Exist to for as a gunseculingit Cause (Disease or iinjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ ned by the atten edetached for u 3 in the past 12 months?
1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be de by 2 No 3 Probably 4 Unknown 1 Yes Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending n 24 hours after death.

e Funeral Director: After the fur the 1 Yes 2 No Investigation Could not be Accident 6 🗆 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier within 24 hou

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completed file Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 worrlow 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Apr 1.26 PM 201 vans Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8 Date of Birth Month, Day Birthplace (State or Foreign Country) If Under 1 Year last birthday 54 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Himore 10g. Citizen of What Country? 10e. Street and Number Was Developed Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College_(1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rober 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Back. md, 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, reading to himself accuse. Enter Underlying Due to for ea a conscittions off Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Prysician/ Medical Examiner signed by the attending physician and be detached for use as the burial-trans ospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 -dward Evans hours after deatl

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permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.

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Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

ed filled in by the funeral director,

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in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of deat 9 Unknown				Month Day Year				
Part II. Other significant conditions of	ontributing to death but not resulting	ng in the underlying	cause given in Part f.		o use contribute to the cause of death? 2 No 3 Probably 4 onknown				
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No				
5. Was case referred medical	26. Place of Death (Check only one)								
examiner? 1 Yes 2 No	Hospital:	/Outpatient 3 🗆 D	OA Other: 4 Nursing H	lome 5 Residence	6 Other (Specify)				
27. Man r of Death 1 ▼ Natural 5 □ Pending 2 □ Accident Investigation	(Month, Day, Year)	b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how in	ury occurred				
3 Suicide 6 Could not b	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factor	y, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)				
(Check 2 Medical Exami	sician: To the best of my knowledginer: On the basis of examination an se Practioner: To the best of my kn	nd/or investigation, in	my opinion, death occurred	at the time, date and pla	ice, and due to the cause(s) and manner stated.				
29b. Signatury and title of certifier	1	29	c. License number	29d. I	Date signed (Month, Day, Year)				
Al mail	V		40603	0	(178/2011.				

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DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Mary and Penarting 15914 and Mental Hygien [] | for State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 **ELWOOD** ANDRE FRINK 4:55 DM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **ARBUTUS** BALTIMORE 1147 COURTNEY ROAD 8. Date of Birti 07-09-19619. Birthplace (State or Foreign Birthplac Country) If Under 1 Year If Under 24 Hrs. Funeral 5. Social Security Number . Age (In yrs, last birthday) Months (Month, Day, Year) 1 XM 2 🗆 F Days Hours Min. 218-82-1063 49 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE **ARBUTUS** 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1147 COURTNEY ROAD 21227 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CORRECTIONAL OFFICER 12 PRISON SYSTRM is marked other Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OOD FRINK Elwood Frink BARBARA WORLEY permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRINK /MOTHER 6806 LENBURN RD., BALTIMORE, MD 21207 BARBARA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET 05/05/2011 OWINGS MILLS, MD ure of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signa 1701 LAURENS ST., BALTO., MD 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \(\square\) Nursing Home Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation М after death Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a To the Funeral D Medical 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print) rimble lo 31. Date filed (Month, Day, Year State 2 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lassler 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltmore rland Medical hiversit If Under 1 Year | If Under 24 Hrs. 5 Social Security Date of Birth **Funeral** 1 □ M 2 🖔 F Days Hours Min 135-52-9507 54 **Director** 05/03/1956 NJ Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Ex miner must be notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 BARTOL ROAD 21209 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE 1 ∐ Yes 2 X No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL 5+ REGISTERED NURSE 17, Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 Is marked oth SHERMAN ZASSLER **ELEANOR** PHILIP ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 BARTOL ROAD, BALTIMORE, MD 21209 SCOTT FERENCE / HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 04/24/2011 RANDALLSTOWN, MD CHEVRA AHAVAS CHESED e of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XNo 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1X Inpatient ပို 1 ☐ Yes 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year)

State Registrar 30. Name and address of person who co

Year)

DHMH 17 Rev 1/2001

(Type, Print)

Z South Greene St. Baltmore, NO 2/201

ppleted cause of death (Item 23a)

Ferraro, Elaine

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	1. Decedent's Name (First, Middle, Last)									2. Date of Death					
	Physicia Medi		Elaine C. Ferraro							Month April	25. Da	2011	Year	8:35	AM M
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	Funeral Director		437-44-1013											ace (State or I Sana	Foreign
	ind show at	5	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation						110	d. Inside City	Limits
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	the N		10e. Street and Number				10f. Zip Code			· · · · · · · · · · · · · · · · · · ·	10g. Ci	tizen of WI	hat Count	ry?	
	s 23; nust I	nera	205 Henry's Mill	Drive			2.	1811				USA	A		
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 ☑ No Specify:					14. Race - American Indian Black, White, etc. Specify: white			tc.			
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Nar	shou and is m raum		19a. Informant's Name/Relationship (Typ			19b. Mailin	g Address (Street a	and Numbe	er or Rural F	Route Numbe	r, City or	Town, Sta	te, Zip C	ode)	
e)	and 2 Health em 2 ther t		Theodore Ferrard 20a. Method of Disposition	/spouse			Henry's 1	Mill	Drive	Berli			1811		
Baltimore,	permit. Page 1 a Department of the Important: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 🔯 Donation 5 ☐ Other (Specify)		cen	netery, crem	sition (Name of atory or other plac		Dat			ocation - C		·	
Ba	permit Depar Impor any in		21. Signature of Funeral Stryice Lice as Ron 1 d S	Dire Dire	ector	22 S	Name and Addres tate Anat altimore	s of Facility Omy I	Board 2120	655 W	. Ва	ltimo	ore S	treet	
- f	nysician/ Medical Examiner	her	23a. Part 1. Enter the disease, or complishock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minimalist.	cations that cause e cause on each line Die to (or as	e. tot a consequer	nce of):	r the mode of dying	g, such as o	1	espiratory ar				Approximate Interval Betwe Onset and De	
	ificate be executed og physician and as the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):									
. Box 68760	that the death certificate be ned by the attending physici e detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	leath 3 🔲						23d. Date of delivery Month Day Ye			ar		
ds, P.O.	d de th	þ	That it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.							23e, Did tobacco use contribute to the cause of d					
Division of Vital Records,	to the nospital or Autending Prysician: The law requires, within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Completed								24a. Was autop perfo 1 Yes		pri	or to com ath?	sy findings ava	ailable se of
<u>.</u>	ertific ctor,	Be (25. Was case referred to medical examiner?				26. Pla	ice of Deatl	h (Check o		7				
>	nysik this c	၉	T L Tes 2 No	1	ent 2 EF		3 DOA Othe	r: 4 🗌 Nur	rsing Home	5 Resid	lence 6	Other	(Specify)		
ouo	tending releath.	Certificate:	27. Manger of D th Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be	28a. Date of inju (Month, Day	ry 28 v, Year)	Bb. Time of injury	28c. Injury work? M 1 🗆			28d. Describe how injury occurred					
DIVIS	utal or Au urs after d ral Direct lled in by	al Cert	4 Homicide determined 25e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	ne nosp in 24 hor he Fune ipleted fi	Medical	29a. Certifier (Check Only One) 3 Certifying Physic	er: Un the basis of e	xamination ai	nd/or investig	nation in my oninio	n death occ	curred at the	e atch amit c	nd place	and due to	the caus	o(e) and manne	er stated.
	vith vith com	<	29b Signature and title of certifier	24	m		29c. License		78			e signed (I	Month, Da	ay, Year)	
			30. Name and address of person who con	Cuestal	Hospin	e po	BOX173	5_5	alis	4.	pul))	18	0>	
	Stat Registra	٠.	31. Date filed (Month, Day, Year) NAY 0 2 2011	32. Registra	r's Sign ture	barks	1			0					

DHMH 17 Rev 7/2009

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			1 - State of Ma		artment of Health an rtificate of Death		jiene eg. No 201	1 13936		
			Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death		
	Physici /Medio		Paul A. Fernandez			April 7		1:10 PMM		
	Examin		A. F. Wh. March 1 and a standard of Double							
			102 N. Brook Lane		Bethesda		Montgo	mery		
	Funeral		457.4.00	(In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours I	Hrs. 8. Date of Birtl Min. (Month, Day	Year	D. Birthplace (State or Foreign Country) Florida		
	Director		203-10-4344	87 Yrs.	, ,	Min. Aug 8,	1923	Florida		
	and		Usual Residence of Decedent 10a. State 10b. County	10c, City, Town or Lo	cation			10d. Inside City Limits		
	/aryll	ō	MD Montgomery	B ₄	ethesda			1 □ Yes 27 No		
	the 128a	Director	10e. Street and Number		10f. Zip Code		log. Citizen of Wh	at Country?		
	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show in item Exaning the molified at		102 N. Brook Lane			814	U	SA		
	ms 2	Funeral	11 Marital Status 12. Was Decedent E	ver in U.S. 13. V	L Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, F	? (Specify Yes or No-		American Indian,		
۵	or ite		1 Never Married 2 Married 1 Never Married 2 Narried 1 N	0		uerto Rican, etc.)		White, etc. white		
5-0036	raf", c	p		43-46	1 □Yes 2X No Specify:		Specify:	WILLE		
Ċ	22	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of	working	16b. Kind of Busin	ness/Industry		
7	d within giene. sr than " tre Med	ם	Elementary/Secondary (0-12) College (1-4or 5+	life I	DO NOT use retired)					
· V		S	12 5+		teacher	VE 1.141.181		eation		
	~ = 0 2	Be	17. Father's Name (First, Middle, Last) Leon Fernandez			Name (First, Middle, Laida Gard				
Ĕ	2 should be and Menta Is marked is raumatic ev	은	19a. Informant's Name/Relationship (Type. Print)	405 Mailin	ng Address (Street and Number of			tata Zin Codo)		
<u> </u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		Scott Matejik/guardian	5202	Roosevelt Stre	et Bethes	la, MD 2	20814		
ā,	Hea Hea tem 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - Ci	ity or Town, State		
altimore,	ages ent of ht: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Donation 5 ☐ Other (Specify)	cemetery, crer	natory or other place)					
	ortar ortar Injur		21 Circulator of Europeal Operation Licenses	. 22	Name and Address of Facility State Anatomy Be	1 655 11	Dol+i-	ama Ctraat		
ä	Depar Impo any Ir	5 15	Ronald State, Dire		Baltimore, MD		. Daiting	ore street		
			23a. Part Enter the disease, or complications that caused shock, & heart failure. List only one cause on each line				rest,	Approximate		
F	hysician	i a	Immediate Cause (Final	tastasic	Postate	Cance	Υ.	Approximate Interval Between Onset and Death		
v	/Medical		resulting in death)	consequence of):	1. 1.)				
E	Examiner		Art Art	remicle	whe Ite	anst d	seeme			
	D ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):		1	. 1 .			
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68760,	care of physic the p	edical	d	<u> </u>						
ָּ X	ding	/Me	IF FEMALE: 23c. If yes, outcome of	f pregnancy		17				
žog.	atten for us	ian	in the past 12 months?	PE Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date Mont			
5	the diched	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	unie or death 5 L	Other (specify)					
7.	mar red by deta		Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?		
ecords	n sign Id be	d by				1 □ Y	es 2 □ No 3	☐ Probably 4 ☐ Unknown		
S	w red s been shou	Completed				24a. Was a	n 24b We	ere autopsy findings available		
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VITAI	tificat		25. Was case referred to medical		26 Place of	1 ☐ Yes Death (Check only or	<u> </u>	□Yes 2 □No		
S :	ysicii s cer direct	To Be	examiner?	t 2 ER/Outpatier	Other:	ng Home 5 Resid		(Specify)		
0	ung rnystolan; The law h. After this certificate has funeral director, page 2 a	Ë	27. Manner of Death 28a. Date of Injury	/ 28b. Time of			ow injury occurred			
SION	ath.	atio	2 Accident investigation	reary injury	M 1 ☐ Yes 2 ☐ No					
<u>"</u>	r Aur	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur	y - At home, farm, stre (Specify)	eet, factory, office	28f. Location (S City or Tow		or Rural Route Number,		
ב ב	irs af					_ \				
	Fune Fune	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of and manner state	examination and/or in	n occurred at the time, date and prestigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and man date and place, an	ner as stated. d due to the cause(s)		
1	To tre morphal or Attendants in the law requires that the deam certificate be executed within 24 hours affer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	one) and manner state	eu.	29c. License number	1	29d. Date signed ((Month, Day, Year)		
, i	- ≯ ⊨ ŏ		1 Milder	parameter	D53	691	00-12	- hali		
,			30. Name and address of person who completed cause of de	ath (Item 23a) (Type	Print) 7~	1 702	2011	1211		
				Enny	Mrs 250	Rocker	11,	1200 d		
	Sta			's Signature				All The State of t		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A pril 25^{Day} 2011 Donald Richard Finberg 2:27 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**M 2 □ F Days Months Min. Month, Day, Hours **Director** 022-24-7083 79 No. Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Virginia Fairfax McLean 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8370 Greensboro Dr. Apt. 701 U.S.A. 22102 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Dîplomat Foreign Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Chester Frederick Finberg Ann Gorfinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 Hela Finberg /Wife 8370 Greensboro Dr., Apt. 701, McLean, Va. 22102 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mometry, crematry, or other place) Cremation Services Apr. 28, 201 Chantilly, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Money & King Funeral Home, Gary Downer 171 W. Maple Ave., Vienna, Va. 22180 CCO 508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Vasculitis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Wegner's Granulomatosis Sequentially list conditions, 1 Year cause. Enter Underlying Cause (Disease or iinjury physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 🔏 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Division of Vital 24 hours after death. Funeral Director: A To the Within 2 To the

Box 68760

Records,

25 1 State

Paul B. Baker, MD31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

April 25, 2011

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D35112

1500 Forest Glen Road, Silver Spring, Maryland

MAY 02

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3938 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year a Medical 4a. Facility Name (if not institution, give sweet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ma If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Ye 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Director March 22 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? Funeral MJ 12. Was Decedent Eve in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married b Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes Give Specify 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working esial life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) oun Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) mmono envio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mt. Holly Dimo 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State (0-201) 4 Donation 5 Other (Specify) Crematater ure of Funeral Service Lice ise 22. Name and Address of acility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of wing, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerrhythmi disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner end stage DESEase renal Sequentially list conditions, it day leading to in mediate cause. Enter Underlying Examine Dun to (or es a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 2 A No this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita 2 No Other: 1 Tes ျှ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowled ge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Katie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Shafter 32.

D0062689

Kaven

April 26, 2011

Blod. Backornd, 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ARROLL 201 23 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 216th Street Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 22 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗷 M 2 🗆 F Days Hours Min. Yrs. Director 213-28-1883 80 Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 K Yes 2 No N/A Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4002 Sixth Street 21225 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Upholsterer N/A David Edward Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Washington Fisher Mary Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John C. Fisher (Son)</u> 757 216th Street Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 04/28/2011 Glen Burnie, Maryland 21. Signature of Juneral Service Licenses ^{22. Name and Address of Facility}
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician agorth. disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any harmonical cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a nonsequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Unknown Day Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has **Director:** After this certificate d in by the funeral director, page 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Tes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be within 24 hours after dex To the Funeral Directon completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 3940 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:45 am 2011 April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner timo 8. Date of Birth Sex 1 M 2 D F If Under If Under 9. Birthplace (State or Foreign **Funeral** ge (In . Davs Months Hours 10/26/3 Country) 217-24-8010 **Director** MD Usual Residence of Decedent 10c. City, Town or Location Baltimore 10a. State notified at with the Maryland 10d. Inside City Limits Director N/A MD 28a-f 1 X Yes 2 No 10e Street and Number 10f. Zin Code ö 10g. Citizen of What Country? must be Funeral 23a 21206 USA 4517 Marx Ave filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1

1 Yes 2 □ No
If Yes, Give Year or Dates 1950 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 'natural", or þ 1 Never Married 2 Married timore, Maryland 21215-0036 African 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Amer the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. City Of Balt. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i and Mental F ဂ James H. Gilchrist should be Rosetta Ball-Boynton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4517 Marx Ave., Balt., MD 21206 Jane Barnes/Daughter item 27 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If its
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Nat 5/6/11 Catonsville,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral dervice Licensee Hari 22. Name and Address of Facility5126 Belair RdBalt., MD 21206 P Close Hari P.Close F.Svs, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -Ph sician/ disease or condition Medical resulting in death) Examiner 10 Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of physician and the burial-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical ivision of Vital Records, P.O. Box 68760 ası the attending IF FEMALE: nse 9 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? łō Month Day Year Pregnant at time of death 1 Yes 2 g Unknown signed by the a Id be detached f g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 s certificate has autopsy performed' 2 400 Yes 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? n 24 hours after deau.. ne **Funeral Director**: After this ce neleted filled in by the funeral dire 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check within 2

To the I

comple only one) the 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) ۵ 30. Name and address of person who completed cause of death (Item 23a) (Type 3 wall accor le mp-

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MOX-09-2011 TRAVES 2:31P. Medical 4a. Facility Name (If not institution, give street and number) **Examiner** County of Death NonTG OMERY (Trove HOSPITAL ROCKVIIIE If Under 1 Year | If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 □ M 2 🗡 F **Director** ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY ERMANTOWN 1 Yes 2 No 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral -/A9hARBOR USA 0874 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OPERATOR 17. Father's Name (First, Middle, Last)

Craves Be 18. Mother's Name (First, Middle, Maiden Surn ည ATHERINE t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Fural Route Number CAPITAL HEIGHTS, MD Graves brother 20743 HEIGHTS, MD., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAleake 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 Deremation 3 D Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Serace Licensee 22 Name and Address of Facility HENRY FUNEVAL Home Jemu Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disseminated intravascular coaqulation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner acute tailure renal Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that introduced to the conditions). Due to (or as a consequence of) acidosis severe metabolic attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical with cirrhosis tailurt Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cholangitis Sclevosina 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital ၉ 1X Inpatient 2 ER/Outpatient 3 DOA Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Suicide Investigation 1 Yes 2 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number Amare Abebe MD April 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, maryland 20850 MD 32. Regist ar's Sign ature State Registrar

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1431

ROLVN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Robert Richard Gay Sr. 2. Date of Death 3. Time of Death Physician/ 2011 11:52PM 20 APREL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ARBOR HOSPITA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) Director 216-42-1209 1944 66 15 August Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2XX No Marvland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a o Funeral 925 Mount Desert Harbor 21122 United States . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, White, etc. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XX Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify White 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 hof Health and Mental Hygiene. item 27 is marked other than "nother traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Automobile Recycling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Richard Gaw Ethel Cookerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 Mount Desert Harbor, Pasadena, Maryland 21122 permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr Frances Elizabeth Gaw Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 ▼ Burlal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Memorial 4/26/2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc 21. Signature of Funeral Service Licenses 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MEULITU 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: performed 2 🗌 No 1 Yes 25. Was case referred to medical filled in by the funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No မ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? | hours after death uneral Director: / Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MASRI 001 HANOVER STREET, BALTIMORE, MD 21225 Dr. HASSAN TH Year) 31. Date filed (Month, Day, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Harlow Goble Eugene 10:30 A M Apri] 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Aberdeen 46 Valley Bottom Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 8 Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Days 2/28/1935 Min 76 **Director** 230-42-8890 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Harford Aberdeen 1 🗶 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 46 Valley Bottom Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 9 þ 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene.
item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fork Lift Operator Concrete 3 0 ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Luther Goble Dora Kestner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Valley Bottom Rd, Aberdeen, MD 21001 Robert Goble / Son or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State West Chester, R.A. Ferris & Co. 4/30/2011 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania Signature of Experal Pervice Licen 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the dis-se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 00014 Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

With the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? the Hospital or Attending Physician: The hin 24 hours after death.

the Funeral Director: After this certificate h 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 > Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ano ARMO 31. Date filed (Month, Day, Year)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 3944 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1 1: 40AM 2.5 Medical 4a. Facility Name (if not institution, give street and number) 46 City Town or Location of Death County of Death **Examiner** Tate House Linthicum Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Kentucky 1 🔀 M 2 🗆 F 286-24-4133 Yrs. Director 81 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 X No MD Jessup 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1943 Montevideo Road 20794 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1951 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 1953 Specify: Completed 3 Widowed 4 XX Xivorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the once. Letter Carrier Il Hygie Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Otis Kendall Hayden Elizabeth Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kendall T. Hayden - son 1943 Montevideo Road, Jessup, Maryland 20794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem Park | 05-02-2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signa MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ -acdionyopa disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death signed by the a 2 🗌 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed? 2 🗷 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: Hospice Hou မ 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 ANatural iniury work? 5 Pending 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature 29c. License number 29d. Date signed (Month, Day, Year, use of death (Item 23a) (Type, Print Date filed (Month, Day, State Registrar

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within 24 hours a Medical completely 29d. Date signed (Month, Day, 29b. Signature and title of centrier 29c. License number D0063145 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 705 Digital Drive, Linthicum, Maryland Arvind Desgi. MDStrar's Signatur 31. Date filed (Month State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar 3946 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Thomas H. Hale</u> 2011 Medical 2:48 April а 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 8. Date of Birth (Month, Day, **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min. 1 🔀 M 2 🗆 F Hours 75 Director 2-15-1935 Washington, dc 46 10a, State 10b. County the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Washington ¹X Yes 2 ☐ No DC ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a oi must be Funeral 816 51 st. NE USA 20019 items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Examiner Black, White, etc ō þ 1 XNever Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", Specify:Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Produce Delivery Private ulth and Mental Hygie 27 is marked other r traumatic event, ti other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Hale Lottie Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health 816 51 St. NE Washington, DC 20019 Tawana Thornton/Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State injury or Department of Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 5/7/2011 Riverdale, Maryland 21 Signature of Juneral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Maryland 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical certificate be P.O. Box 68760 the as ding IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) for in the past 12 months? Month Dav Year Pregnant at time of death 2 No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ ER/Outpatient 3 DOA 1 📈 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No Natural 5 Pending injury hours after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 43 371 completed cause of death (Item 23a) (Type, Print) AAMC State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Μ. Hooker 2011 Grace 11:20 P M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Dunda1k 1853 Portship Road If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours April 22 1 🗆 M 2 🗓 F 94 Maryland **Director** Yrs. 216-03-5979 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dundalk 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21222 1853 Portship Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Peter Schauer Frances Schaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherma L. Quick (Daughter) 1853 Portship Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 4/30/2011 Middle River, MD 22. Name and Address of Facility Duda-kuck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service Lie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner AUCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2.2 No After this certificate 1 ☐ Yes 2 ☐ No Yes a 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident ☐ Suicide Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 0014221

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registraris Signature

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Patricia Anne Holthaus 2011 2:00 April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5417 Todd Avenue N/A Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours 06-14-1933 1 M 2 X F Yrs **Director** 212-30-0893 77 Maryland Usual Residence of Decedent 28a-f shov 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5417 Todd Avenue 21206 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. ò ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", Specify: Completed 3 ▼ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas Hefner Katherine Polley permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21206 Marykay Holthaus - Daughter 5417 Todd Avenue injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Parkwood Cemetery 04-26-2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road ğ Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only orle-cause on each line. Approximate on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Crohn Sequentially list conditions, if any tracing to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ malnutrition 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy insufficience perform 2 🗌 No 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🖵 🧲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rosert Alcheri MD 25 Crossroads 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10a per fh 915 5-2-11 yt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HENIGHAN EVELVI 6:50P.M Medical 4a. Facility Name (if not institution, give street and number, Examiner City, Town, or Location of Death Ewisville Place Harles DUNTY ryantown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 F Hours Min 579-26-5181 Director Usual Residence of Decedent or 28a-f show 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director DC. Washington 1 🗌 Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a SA 20018 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLack 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ERICA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henighan Janie (unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EWISVIlle Pl., Bryantown MD. 20617 Sandra Gaddy /claughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■ Burial 2 □ Cremation 3 □ Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) INCOLN 420 H S+ n.E. Signature of Funeral Service Licensee any .K. HENRY Funeral Home WASH. D.C., 20002 Part Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be east hours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) HILL Hospital 1 Yes 2 No Other: ပ 4 Nursing Home 5 Residence 6 Pother (Specify) Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Fractioner: To the best of my knowledge, death accumed at the firm, date and plane, and due to the cause(s) and manner as state. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B1. Date filed (Month, Day, Year) 32. Registrar's Signature 0 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3950 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hick Month Physician/ Day Year 98 : 48 AM Ō Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Harford Memorial Hospital <u> Havre de Grace</u> 8. Date of Birth (Month, Day, Year) May 16, 1938 Social Security Number Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Hours Months West Virginia Director 72 Yrs. 235-60-4045 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🛚 Yes 2 🗆 No Maryland Harford Aberdeen or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 904 Barnett Lane #303 21001 USA items 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc or þ 1 Never Married 2 Married 1 ☐ Yes 2**XX**No If Yes, Give 21215-0036 1 ☐ Yes 2 XNo Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Specify: white 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 restaurant waitress Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Minnie Bell George L. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Smith (daughter) Page 1 and 2 310 Redbud Road, Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of F 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) .A.Ferris & Company 4/29/2011 West Chester, P.A. 21. Signature of Funeral Service Licensee maryland 21001 Funeral Home, P.A. Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) OU S Medical Due to (or as a consequence of): Examiner Disease Orona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death led by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 Yes director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of ivision of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 98 0099 ompleted cause of death (Item 23a) (Type, Print) HAURE 31. Date filed (Month, Day, Year) 32. State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mamie's Loving Care Assited Living Ft. Washington PG Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 12-27-1922 Days Hours 216-18-5400 MaryTand **Director** 88 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD PG Fort Washington 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 **USA** 522 Kisconko Turn 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed Specify: Black 3 Widowed 4 XDivorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cashier Walter Reed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Finley Helen Calhoun Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2150 Washington Dr. Douglasville, GA 30135 Leslie Martin/Son L. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot cemetery, crematory or other place)
Ft. Lincoln Cemetery 1 X Burial 2 Cremation 3 Removal from State 4-29-11 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH Signature of Funeral Service License (Onal 10583 Middleport Ln. White Plains,MD 23a. Part 1. Enter the disease, or complications hat caused shock, or heart failure. List only one cause on each line. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Touch disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 certificate 1 \(\text{Yes} To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 💆 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check з 🗌 Septifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the 29d. Date signed (Monfin, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Bisck Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2011 12:35 William Johnson ΩA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St Thomas Moore Nursing & Rehab Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1X M 2 □ F Months Days Hours 09-19-1962 577-92-5816 Vashington DC 48 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director Forestville PG MD 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5 USA items 23a Funeral 20747 2725 Lorring Dr. #301 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? ö þ 1 Never Married 2X Married Specify: Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) East-West Housekeeping Housekeeper 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Johnson Evelyn William King permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 28th St. SE #4 Washington DC 20020 19a. Informant's Name/Relationship (Type, Print) Felicia Johnson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Heritage Memorial Pk 05-09-11 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Onset and Death Immediate Cause (Final Physician/ HUFRIOSCI PARS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CINOST 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed enal 145UFF 1 Tyes Yes 2 No certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other: မ Within 24 hours after death.

To the Funeral Director: After this of 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Ad Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Tes 2 \square No 2 ☐ Accident 3 ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) gted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Anna Kegg Apri. 2011 4:37P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Hours April 28, 1925 415-24-0552 86 Yrs Tennessee Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Timonium 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road, Unit L-412 Funeral 21093 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Accounting Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Myrtle Mae Derryberry John Joyner Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Earl C. Kegg/ Husband 2525Pot Spring Road, Unitl-412, Timonium, Maryland21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation, Inc. 5-2-11 Hanover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel P.A. marque 6009Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of the attending physician and the for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2 s autops 2 \square No Νo 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury 5 Pending 1 Yes 2 🗆 Na Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, To the Hospital on within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npleted (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month. Dav. Year) 2011 30. Name and address of pers 31. Date filed (Month, Day, Year) 32. Re State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rian Michael Ka		Ski 1- For State Registrar	State o	f Maryland		ment of l		d Menta	al Hygie		20	Prottoment	13954
Physicia	ın/	1. Decedent's Name								ate of Death onth	Day Yea	ır	3. Time of Death 1816 hrs
Medical Exami	ner	Brian I	Michael			Lab	. City, Town, or	Location of		oril 28, 20	111 4c. County of	of Death	10101115
		-	n Branch Drive	street and number,			Ellicott City	Location of	Death		Howard	or Bourn	
Funeral		5. Social Security Nu	umber 6. Sex	7. Ag	e (In yrs. last b	irthday)	If Under 1 Year		_	Date of Birth	(MM/DD/YYYY		hplace (State or
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Baltimore, permit. Pages I ar Department of Hee Important: If the	ı	21. Singular of Fun					me and Address					_	
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ox 6876C sath certificate attending phys	an/	23b. Was decedent p past 12 months?		1 Live birth			I death 3	Ectopic	pregnancy		Month		ay Year
Box 6876 death certificate the attending phy	Physician/M	1 Yes 2 No	o 9 Unknown	9 Unknown	t time of death	5 Othe	r (Specify)						
. a + a		Part II. Other signifi	icant conditions	ontributing to deat	h but not result	ting in the un	derlying cause g	jiven in Par	t I.	23e. Did tob	acco use contr	ibute to	he cause of death?
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f Vil	P	1 ✓ Yes 2 27. Manner of Death	No No	28a. Date of Inju		Outpatient b. Time of Inj		ry at Work?	Nursing Ho		Residence 6 ow injury occum		Scene
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Division ral or Atteodi rs after death.	licat	2 Accident 3 Suicide	Investigation 6 Could not be	28e Place of Ir		07 hrs , farm, street,	factory, office b	uilding, etc				er or Ru	ral Route Number, City
Division Bospital or Atteod 24 hours after death Funeral Director:	Certification:	3 Suicide 4 Homicide	determined	(Specify) Ap	artment					or Town, Sta LAutumn E	ate) Branch Drive,	Ellicott	City, MD
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		23b. Signature and t	23 //	211			O.C.I				April 29, 20		, = 4,, , 64.,
121		30. Name and address	ss of person who con	mpleted cause of	death (Item 23a	a)	1						
ITIV		Pamela E. S		Assistant Med			W. Baltimore	e Street,	Baltimor	e, MD 21	223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:30 PM Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** timore atonsville Haven Home a If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Ace (In vrs. last birthday) **Funeral** 1 M 2 x F Months Days Hours Min 7-122-1947 Marvland 63 Yrs. 212-48-4860 Director Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2X No MD Howard Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 3264 Normandy Woods Drive #H 21043 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Black White etc. ō þ 1 Never Married 2 Married Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry within I Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the Agone. Telecommunications Co. Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Charlotte Elizabeth Schmitt John Norman Strube 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9535 Star Moon Lane Laurel, MD 20723 (Daughter) Pamella Ann Kudwa 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ery crematory or other place)
View Memorial 4 Donation 5 Other (Specify) 4-29-2011 Sykesville, 21. Signature o Funeral Service 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Columbia, MD 21045 Part 1. Enter the disease shock, or heart failure ist 23a. Part 1. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nly one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? ó Day Year Pregnant at time of death 2 No the be detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown pluods 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No certificate has page 2 death? 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. M Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6095hou man 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🗸 📗 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27^{Day} 201^{Year} $\mathrm{Ap}^{\mathtt{Month}}_{\mathbf{r}} 1$ Kostkowski 8:30 PM Virginia Theresa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Transitions Health Care Sykesville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept5,1928 Maryland 217-24-2421 82 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore City Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? J Hygiene. Jother than "natural", or items 23a or vent, the Medical Examiner must be r Funeral 21224 U.S.A. 2622 Fait Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Factory 8th Laborer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Catherine Piekarska Frank Zaranski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4707 Winksley Court Ellicott City, Md21043 19a. Informant's Name/Relationship (Type, Print) Joseph L. Kostkowski/son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of MayDate Sacred Hrt of Jesus 2,2011 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility aczorowski Funeral Home, P.A. Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ emention disease or condition , Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier D 43725 April 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Tariq Mahmood, M.D. 19 Ridge Road Westminster, Maryland 21157 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

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21215-0036	filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2	Decedent Ever in U.S. ed Forces? If			Was Decedent of Hispanic Origin? (Specify Yes or Nof Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American India Black, White, etc. Specify: BLACK				
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altimore,	Page tment c tant: If jury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp							05-0	4-2011	OWI	NGS	MILL	S, MD		
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		2 0	23a. Part 1. Enter the disease, or c	omplications that caused	the death						BALTO.		2121	7	Approximate		
	ກາງຣາເວັດກາ	7 IS	snock, or heart failure. List on Immediate Cause (Final	y one cause on each line	. /	1.			4	1.		,			Interval Between Onset and Death		
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a			ovona.	ry ell	Teny	disc	a se			-	Unthrown.	-	
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л О	is unat u igned by be detac	by	Part II. Other significant condition Prostate Cau	-	ontributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b State of Waryland Department of Health and Mental Hygiene | | | For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1500 allmore 2011 8:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number 8. Date of Birth (Month, Day, Year) Aug 29, 1927 9. Birthplace (State or Foreign Country) Washington DC **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 🕅 M 2 🗆 F Days Hours 83 Director 218-20-0268 Aug Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County Howard 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Woodbine 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3425 Hipsley Mill Road 21797 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 ⚠ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", 3 X Widowed 4 ☐ Divorced 45-46 Specify: Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 CPA financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Price Theophilus Brown Larimore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Iron Rail Court Woodbine, MD 21797 Tom Larimore/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Qther (Specify) Signature of Funeral Service Licenses Ronald S. Wante 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examir the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Physician/Medical nding p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? been signed by the atte should be detached for Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autonsy death? Yes 2 N 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 26 2011 1CC1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 1/2001

State

Year)

31. Date filed (Month. Day

Division of Vital Records, P.O. Box 68760,

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Welford J. Lotsey April 201Î 7:26 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2510 Gray Manor Terrace Baltimore Co. Dunda1k Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Hours 1 X M 2 🗆 Months Days March I5, 1925 **Director** Maryland 212-20-5913 86 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Dunda1k 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2510 Gray Manor Terrace 21222 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1XXYes 2 \(\subseteq \) No If Yes, Give Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3

∭ Widowed 4 □ Divorced Completed WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electrician-Bethlehem Steel Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert S. Lotsey permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Ella H. West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ava L. Magrogan (Daughter) 8369 Forest Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🗆 Burial 2 🕅 Cremation 3 🗀 Removal from State Donation 5 - Other (Specify) 5/2/2011 Hilltop Serv. Corp. Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7022 Wise Avenue Dundalk, Maryland 21222
Approx 21. Sign tur f Funeral Service License Part 1. Since the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiin Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transi unsure su that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed les Catheter 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy malnuslund performe this certificate! 1 Yes 2 No 1 Yes 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 2 🗹 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident s after death Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier aurasco 0-25097 waed 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia Rd. Suite 108, Bult. Md. 21237 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A Deic Young Sook Malabey 4.50 A M 25 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death ANNE BALTIMOPE WASHINGTON MEDICALCE CHEN Social Security Numbe **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months 1 🗆 M 2 🕱 F 100-21-1935 CountryKorea 566-23-9338 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i Funeral 7972 Nolpark Court, Apt. 302 21061 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. β 1 Never Married 2 Married MACABEY, YOUNG Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 X Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jong Seon Kim Yong Kang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s. Department of Health a Important: If item 27 is any injury or Antonette K. Crego - daughter 4120 Nutwood Way, Fairfax, Virginia 22032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park | 05-05-2011 | 4 ☐ Dona#ton 5 ☐ Other (Specify) Elkridge, Maryland 21, Signature f Funeral Service Lie 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, sician/ TASTATIC disease or condition resulting in death) Medical Examiner AIMOMIL Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Sue to for as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ 1 Yes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas page performed After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending s after death.

I Director. Aff
ad in by the fur 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one D 45149 2011 who completed cause of death (Item 23a) (Type Print) Glen Rumie mis 301 Hos mal State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P. 201 Physician/ Month Clara E. Mayo M 28, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2418 E. Hoffman St. Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2√ Months 85 19-07-442 Yrs. Director Sept 1925 VΑ show 10b. County 10a State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f MD Baltimore X ☐ Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 2418 E. Hoffman St. 21213 23a USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ö by 1 Never Married 2 Married Yes 2 No Specify: Black Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 6th College (1-4 or 5+) the Seamstress Misty Harbor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Wilbert Lambert Mamie Hardgrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald L. Mayo (son) 2418 E. Hoffman St. Balto, Md. 21213 Baltimore, 20b. Place of Disposition (Name of Semetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Most Holy Redeemer May 3,2011 Balto, Md. 1 🕅 Burial 2 □ Cremation 3 □ Removal from State onation 5 Other (Specify) of ture of Funeral Service Licensee Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto,Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Immediate Cause (Final Onserancy Death Physician/ disease or condition Medical resulting in death) Due to 1 r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Imjury Physician/Medical Examine Due to (or as a consequence of): the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy this certificate 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 2 Accident iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted. only one Signature 29d. Date signed (Month. Dav. Year) address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 26 Day McDanie1 2011 Edith 1:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riverview Nursing Center Baltimore Essex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Days Hours Min. June 23 212-20-4661 87 Marvland Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore Baltimore MD. 1 Yes 2 X No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21212 USA 417 Regester Ave. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes Yes, Give 3altimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fischer Luther H. G. Smith Matilda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Regester Ave. Baltimore, MD. 21212 Mary E. Smith/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4-27-11 Towson, MD. Hilltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and ACCRSS Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the dise / e, or co / lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur 2. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Broad Cordinana R. aut Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Al acction 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has death? 2 No 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: fter death. 28d. Describe how injury occurred 1 Natural Hospital or Attending work? injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hereul Flee ono 219667 04-26-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7310 # 508 Glen Brown Haryland 2106/ 32. Registrar's Signature State Registra

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State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David Dean Marsh, Sr. 8,54AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Unde If Under 24 Hrs Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 M 2 - F 216-68-9044 (Month, Day, November Marylar.d 55 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a State 10d. Inside City Limits 10c. City, Town or Location Director MdBaltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 205 Audrey Avenue 21225 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 📆 o Specify Specify. White Completed 3 Widowed 4 X Divorced Year or Dates is marked other than "natur raumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Melvin Jerome Marsh Eileen Francine Harper 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darryl Marsh 205 Audrey Avenue Baltimore , MD 21225 son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of cemetery, crematory or other place)
Bayview Crematory 1 ☐ Burlal 2 🔀 Cremation 3 ☐ Removal from State April 27, 2011 Baltimore, MD 4 Donation 5 Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signatur 237 Fast Patapsco Ave. Baltimore, MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Atheroscherotic Cardiovascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an cate has b prior to completion of cause of death? performed 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗷 No မှ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural work 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated DOOS 8141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wendie Williams, Mi) Caton 5. Balt, more am, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Ap^{Month}l Margaret K. O'Meara 27 10:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX**F Months Hours Min 2/871 82 Year) Country Mary land **Director** 219-20-3501 84 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1619 Sandy Hollow Circle 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Completed by 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hazel Gibson Frank Krepp permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Cecil / Daughter 1619 Sandy Hollow Circle Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 4/30/2011 Timonium, Maryland Signature 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Luneral Service Li Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ 510disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) APRIL 27, 2011 Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been earn. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No O'MEARA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2XN0 Hospital: ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 No Investigation Accident MARGARET Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Theis Chr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 JUSTINE PREIS, CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 23, 2011 Year Eric Gustav Peacher 5:30 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Timonium Brightwood 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ★ M 2 □ F March 27, Year 926 85 216-20-9785 Mary Tand Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Timonium **Baltimore** MD 1 🗆 Yes 2 🗖 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a Funeral 21093 12300 Rosslare Ridge Rd., #402 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White "natural", 44-46 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Methodist Clergy Religion should be filed with and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ပ္ Balbina Stachowska John Peacher 01iver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice E. Peacher-wife 12300 Rosslare Ridge Rd., #402, Timonium, MD 21093 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimore, MD 4/29/11 Moreland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congos truc Heart disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** le montice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No to the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for a Month Day Year Pregnant at time of death 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 ANO 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State
 Registrar

DHMH 17 Rev 7/2009

Linther Ville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

5 Thomas 0

32. Registrar's Signature

			Please	Type or Print in Blac	ck Indelible Ink. Ensure	All Copies					
	State of Maryland / Department of Health and Mental Hygien (
			Registrar	0	Certificate of Death		g. No.				
	Physicia	ın/	Decedent's Name (First, Middle, Las		7 . 11	2. Date of Death Month	Day Year				
m95/ _{31/21}	Medic Examin		4a. Facility Name (if not institution, give	Edward	Powell 4b. City, Town, or Location of Deat	April	26 2011 11:06 AM				
	LAdilli	IGI	0.11.1.1	spice Center	D 11.		4c, county of Death				
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birth		8. Date of Birth	9. Birthplace (State or Foreign Country)				
	Director		213 - 62 - 7912 Usual Residence of Decedent	56	Yrs. Worth's Day's Flodis Willia	01-12-	1955 MD				
	and show	ğ	10a, State 10b. County	10c. City, Town	or Location		10d. Inside City Limits				
	Maryla 28a-f	Director	MD	Bal	timore		1 ☑ Yes 2 ☐ No				
	a or 2		10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?				
	th with	Funeral	833 Reverdy	Rd.	21212		U.S.				
(0	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.				
21215-0036	rs afte ral", e Exan		3 Widowed 4 Divorced	If Yes, Give 1972 - 1984 Year or Dates.	1 ☐ Yes 2 ☑ No Specify:		Specify: Black				
5-0	2 hou "natu	Completed	15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occupation (Give kind of work done during most of wo	rkina 1	6b. Kind of Business Industry				
121	thin 7	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT use retired)		T 11:				
	Hygiene. other than	Be (12 th Grade 17. Father's Name (First, Middle, Last)	B	11/2/21 12/21 12/21	me (First, Middle, Ma	Iransportation				
/an	2 E 3 0	P.	Joseph L	ee Powell	Peggy	Μ.	Everett				
Maryland	should be and Mer is marke raumatic		19a. Informant's Name/Relationship (Ty		. Mailing Address (Street and Number or Ru	ıral Route Number, C					
	1 and 2 strength item 27 other tra		Lancra K. Powe	11 / Wife 83		Balt	more, MD 21212				
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		f Disposition (Name of ry, crematory or other place)	Date 2	0c. Location - Čity or Town, State				
蕇	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21, Signature of Funeral Service Licens	11/10/14/10/	nd Nat'l Cem. 104-		aurel, MD				
Ba	permi Depar Impo any ir once.		7 Julius Service Licens	Xalina 8	22. Name and Address of Facility	ri - State					
					ot enter the mode of dying, such as cardiac						
andr.	h sician/		shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MetaStatic Cause of Unknown Primary DA								
	Medical Examiner		resulting in death)	a. Due to (or as a consequence of	of):	300000	- CHYS				
	LAdillilei	Je.	Sequentially list conditions,	b. —————							
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or de a consequence o	#J:		== ==1				
	e executed tian and urial-transit		that initiated events resulting in death) Last	c. Due to (or as a consequence o	of):	 					
00	cate be e physicia s the buri	Physician/Medical		d							
Box 68760	eath certificate b attending physi d for use as the b	Med	IF FEMALE:								
0×6	ath cel	ian/	in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death			23d. Date of delivery Month Day Year				
ĕ.	ne dea the a	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 U Other (specify)		World Day Tour				
Division of Vital Records, P.O.	requires that the death been signed by the atte should be detached for	by Pt	Part II. Other significant conditions co	ntributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?				
S,	quires en sign uld be	ed b	PROSTATE CA	ncor		1 ☐ Yes	s 2 No 3 Probably 4 Unknown				
Sor	aw reg as bee 2 sho	Completed	SICKLE CEL	LTRACT	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
Вě	The Is ate ha	Com		7. •		perform					
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Che	ck only one)					
Ξ	Physi this cral din	2	1 Yes 2 No	1 Inpatient 2 ER/Out 28a. Date of injury 28b, T		Home 5 Residen 28d. Describe how	ce 6 Other (Specify) HOSPICE				
o uc	nding tth. ; After e fune	cate	1 Natural 5 Pending 2 Accident Investigation		njury work? M 1 Yes 2 No	2od. Describe now	injury occurred				
isio	er des ector by th	Certificate:	3 Sulcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)			et and Number or Rural Route Number,				
Š	ital or irs aft ral Dir led in			building, etc. (Specify)		City or Town,	State)				
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 the hours after death. Within 24 the Jours after death. The funer blackor, After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2 Medical Examin	ner: On the basis of examination and/or	death occured at the time, date and place, r r investigation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s) and manner stated.				
	o the	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	Practioner: To the best of my knowle	edge, death occurred at the time, date and pl 29c. License number		ause(s) and manner as stated. d. Date signed (Month, Day, Year)				
	- > - 0		1 mlls	1/-W							
	/ .		30. Name and address of person who co	ompleted cause of death (Item 23a) (T	Type, Print)		BATTOMORE MOZIZEL				
1	V		MICHAEL A	FAKROW MC	6tol Noverte Class	ues) True	BAITMURE MOZIZE4				
	Stat Registra	.е	31. Date filed (Month, Day, War) - 40 MAY 0.9 20	32. Assistrar's Signature	hered		·				

Division of Vital Rec⁵rds, P.O. Box 68760, Hospital or Attending Physician: this After death. Director:

27. Manner of Death

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Zabiullah Ali, M.D.

5 Pending

Could not be

30. Name and address of person who completed eause of death (Item 23a)

1 Natural

2 Accident

3 Suicide

Day, Year) 31. Date filed (Month Barker

28a. Date of Injury FOUND: Day,Year)

(Specify) Multi-Family Apt.

Apr 13, 2011

and manner stated.

Assistant Medical Examiner

28b. Time of Injury

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

FOUND:

1346 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.

28c. Injury at Work?

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

1 Yes 2 V No

28d. Describe how injury occurred

Subject placed plastic bag over his head

or Town, State) 5225 Pooks Hill Road #6035, Bethesda, MD

April 14, 2011

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:10 pm Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kaven CLE timos & 8. Date of Birth (Month, Day, Year MAY 7 Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 2783 1 X M 2 🗆 F Months Hours Min Country) OWA Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland notified at Director HIMORE 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Ь ral", or items 23a or Examiner must be Clinton Funeral USA 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Was Decedent Even in Co. Armed Forces? 1 X Yes 2 ☐ No MAN If Yes, Give Year or Dates Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ģ 2 No MAVY Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important if item 27 is marked other than "ne any injury or other traumatic event, the Market once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 EAMSTERS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State te, Zip Code) M-RAThMAN 51 MARGARET 35 - WIFE 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Odenton MARY MAND 5-2011 4 Donation 5 Other (Specify) ZANNINO 22. Name and Address of Facility 21. Signature of Funeral Service 22 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the di Approximate Interval Between shock, or heart Onsel and Death Immediate Cause (Fin Physician ementia disease or conditio resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause (Disease or linjury but to for as a consequence of use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? for Month Day Year Pregnant at time of death 2 No should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page 2 performed? this certificate 1 🗌 Yes 2 No Division of Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. May er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After work? injury Natural 5 Pending Investigation Accident the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John S 700 L 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

the Hospital or Attending Physician; The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. filled in by the funeral director, page 2 should be within 24 hours after To the Funeral Direc

Page 1 and 2 should be filed within 72 hours after death with

27

Baltimore, Maryland 21215-0036

CO P1		:ontri	OI.
			_
25. Was case referre examiner?		Hos	sp
27. Manner of Death	_		2
1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investigatio 6 Could not I determined	эе	2

29a. Certifier

_				_				24a. Was an autopsy performed? 1 Yes 2 No	prior to completion of caus death? 1 Yes 2 No		
				_	26. Place o	of Death (Che	ck or	nly one)			
	Hos	spital: 1 Inpatient 2	ER/Outpatient	з 🗆 г	DOA Other: 4	☐ Nursing I	lome	5 Residence 6	Other (Specify)		
	on	28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes	2 🗆 No	280	d. Describe how injury	occurred		
t	be	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			

(Check only one)	Medical Examiner: On the basis of examination of the basis of examination of the basis	nation and/or investigation	on, in my opinion, death occurred at the tirne, date occurred at the time, date and place, and due to	e and place, and due to the cause(s) and manner stated the cause(s) and manner as stated.
29b. Signature and	d title of certifier	MD	29c. License number DST6979	29d. Dale signed (Month, Day, Year) 4/2912011

Run RD Balto, MD 212

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print) Stemm 617 nardon

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 9915 5-2-11 vt
State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 25, Physician/ 201^{Ye} 6:50 PM PHYLLIS ROSENZWEIG Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Min Country) 0371471929 82 Yrs MD Director 214-24-8944 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event the matural once. 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location Director 1 XYes 2 No N/A BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21209 USA 6350 RED CEDAR PLACE, #208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROSE REUBEN GLICK UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 LEAFYDALE TERRACE, BALTIMORE, MD 21208 STUART ROSENZWEIG/SON 20a. Method of Disposition ART of Receipts (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 04/28/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ mouths disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 18 months?

1 Yes 2 No Year Dav Month 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Jas performed' Yes 2 Vol 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ë 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending Certifical 1 Tyes 2 🗌 No Accident Investigation the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 26 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, State 0 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ April 22, 8:10 PM M Louise M. Specht Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sykesville Carroll Fairhaven Nursing & Rehab 8. Date of Birth
Dec 13, 1910 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours 1 M 2 X F Maryland 217-44-2956 100 Director Usual Residence of Decedent . 23a or 28a-f show ast be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director 1 Yes 2x No Sykesville Carrol1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21784 USA 7200 Third Avenue permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health an Mental Hygiene. Important If item 27 is "arked other than "natural", or items 23 any injury or other trau atic event, the Medical Examiner must is a permission. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Ottmar Mast Grace Rebecca Tennent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2403 Boteler Road Brownsville, MD Stephen Specht/son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4
☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licenses Rona Ld 5. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street *M*irector 21201 MD 23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rdiomyo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or linjury that initiated events (as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death been signed by the should be detached P.O. 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe cate has page 2 s Attending Physician: The 1 Yes 2 No Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 100 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 1 Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed (Check To the within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signature and tit 34849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print lam la 31. Date filed (Month, Day, Year) 32. Registrar State

DHMH 17 Rev 7/2009

Registrar

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ISSAC Stivens UNK UNK

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State of Maryland / Department of Health and Mental Hygiene

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	1- For State			Cortifi	cate of L	Death					
Dhysisian/	Registrar 1. Oecedent's Name (Fir	rst Middle Last)		Certin	Cale Of L	Jean		2. Date of D	Reg. No. eath	-	3. Time of Death
Physician/ Medical Examiner								Month April 24	Day	Year	0253 hrs
inculour Examinor	Isaac Ste		et and number)		- 4b	City, Town, o	or Location of Dea			. County of Death	<u> </u>
	University Hosp		ot and named,			Baltimore					
Funeral	Social Security Numb		7. Age	(in yrs. last b	irthday)	If Under 1 Ye	ar If Under 24H	rs. B. Date of	Birth(MM/	DD/YYYY) 9. Bir	thplace (State or
Director						Months Da		in	26/19	Foreig	gin untry) NY
	072-60-08		2 F 3		Yrs.			03/4	20/1	9/4	, NI
any	Usual Residence of Dec 10a, State 10b.	. County	1	Oc. City, Tow	n or Location	1					10d. Inside City Limits
				_							1 X Yes 2 No
Aaryland 28a-f show I at once. Octor	NY Q1	ueens		<u>Jama</u>		10f. Zip Code			10g. Citi	zen of What Cou	ntry?
uth the Maryland 23a or 28a-f sho notified at once. al Director	144-108	106th Av				11435			17 0	.A.	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 23a-f she or other traumatic event, the Medical Examiner must be notified at once To the Traumatic event, the Medical Examiner must be notified at once	11. Marital Status		Was Oecedent E	ver in U.S.	13 Was		ispanic Origin? (Specify Yes or			ican Indian, Black,
er death with 1, or items 23, r must be not	1 Never Married		Armed Forces?				an, Mexican, Puer			White, etc.	
F. F.	3 Widowed 4	1 Divorced If Ye		No No	1 Y	es 2 X N	o specify:			Specify: Bl	ack
urs affu hural" mine	`—————————————————————————————————————	Lor D	ates:	leted) 16a	a. Decedent's	Usual Occupa	ation (Give kind o		16b. k	(ind of Business/	Industry
2 hor	Elementary/Secondar	ry (0-12)	College (1-4 or 5+	·)	during mos	t of working lif	e. DO NOT use r	etired)	1		
Dolor	12			М	over				P	rivate	Company
5-0036 ed within 72 hours ed within 72 hours officer than "natu the Medical Exan Completed	17. Father's Name (First	t, Middle, Last)					1B.Mother's Nar	ne (First, Middl	e, Maiden	Surname)	
, MD 21215-0036 and 2 should be filed within 72 hours aftereath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by		is					Marce.	ll Ste	vens	3	
21 ould d Med d Med To	19a. Informant's Name/F	Relationship (Type,	Print)	- 11	9b. Mailing A	ddress (Stre	et and Number o	r Rural Route N	lumber, C	ity or Town, State	, Zip Code)
MD id 2 shoulth and m 27 is a numatic	Marcell S		(Mothe				6th Ave				
F. Hear Filter	20a. Method of Dispositi		emoval from Stat		of Disposition of the	on (Name of co r place)	emetery,	Date	20c.	Location - City or	Town, State
Pages ent of roth	4 Donation 5	_	emovar nom otat		e Law	n Par	k 5	/2/11	Fa	rmingd	ale, NY
Baltimore, MD 2121(permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, i	21. Signature u er	S rv Licens			22. Na	ne and Addres	ss of Facility Da	avid W	illi	ams F.	s.
E B B B M	120	UV			1108	3-20 S	utphin	Blvd.	, Ja	maica,	NY
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Medical Examiner	Immediate Cause (Final	9.4	iple Gunshot	Wounds							Death
ZXXIIIIICI	or condition resulting in	death) Due t	o (or as a consec	uence of):							
<u>_</u>	Sequentially list condition if any, leading to immed		o (or as a consec	uance of):					_		
nine enine	cause. Enter Underlyin	ng Cause	o (or as a consec	juence or j.							
xau	(Disease or injury that in events resulting in death	nidated	o (or as a consec	uence of):					-		
and trans		d							_		
ox 68760, anthe certificate be executed attending physician and or use as the burial - transit sician/Medical Examinel	UNPENDED	☐ AM	ENDED								
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68° certific nding se as	past 12 months?	The late of the la	Live birth Pregnant at ti	me of death			Ectopic preg	nancy		Month	Day Year
by the attending puched for use as the Physician/	1 Yes 2 No 9	Unknown 9			○ Othe	r (Specify)			237.		
that the done by the detached by Phy	Part II. Other significar	nt conditions conf	ributing to death	but not result	ing in the un	derlying cause	given in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
, P.C res that signed be deta								1 🗆	Yes 2	No 3 Pro	bably 4 Unknown
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COT law r has b	-				 			_ pe	topsy rformed?	death?	completion of cause of
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ician: certifi rector,	examiner?	_ Inospi	1 V Inpatien		o. Time of Inj		ury at Work?			ury occurred	
f Vital Records, Physician: The law requirent in this certificate has been real director, page 2 should To Be Complete.	examiner? 1 ✓ Yes 2	140		/ 28					oe now inii		
n of Vital ding Physician: h. After this certif; funeral director, on: To Be (examiner? 1 ✓ Yes 2	110	28a. Date of Injun (Month, Day Year Apr 24, 2011		47 hrs			Subject s			
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Transi Medical Certification: To Be Completed by Physician/Medical E.	examiner? 1 Yes 2 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 292 Cartifier	Pending Investigation Could not be determined tifying Physician:	28a. Date of Injun (Month Day Yell Apr 24, 2011 28e. Place of Injun (Specify) Side	on on one of the original of t	47 hrs farm, street,	factory, office	Yes 2 V No building, etc.	Subject s 28f. Locatio or Town 4700 Saye	n (Street a n, State) r Avenue ause(s) ar ate and pla	and Number or Ri , Baltimore, Mo	t. ted. ne cause(s)
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 №M 2 □ F 83 220-20-2876 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Baltimore 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give Year or Dates: WW ∏ 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: W/ /2 þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ENGINEER BOO 13 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd . BOITIMORE MIRN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Atlante Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
Important: If It
any Injury or o 1 Burial 2 Cremation 3 Removal from State 40 Crematory 4/28/2011 Golen Burnie MD 22. Name and Address of Facility Bradley - Ashten Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Road Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASCV tears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): rdiopulminary Arrest Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Exami The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 🗌 Live birth 3 Ectopic pregnancy Month Day Year φ 4 🗌 Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 2 2 No 3 Probably 4 Munknown 1 Tes director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 🗌 No 1 Yes certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 24 hours after death. Funeral Director; After Division 5 Pending investigation 1 Yes 2 No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 ☐ Homicide City or Town, State) To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STOWN 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registra's Signature State parkel Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 13975

		1- For State Certificati	e of Death	Reg. I	No.				
Physici		Decedent's Name (First, Middle,Last)	Month Boy Year						
ledical Exam	ine	Ellsworth James Smith		April 19, 201	1 real	1945 hrs			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
		332 Cedar Drive	Salisbury		Wicomico				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd			MM/DD/YYYY) 9. Birth Foreign				
Director		$061-30-6922$ $_{1}\times_{M}$ $_{2}$ $_{F}$ 73	Yrs. Months Days Hours Min	Nov 28,	1937 Cou	ntryNew York			
		Usual Residence of Decedent		1					
' Any		10a. State 10b. County 10c. City, Town or				10d. Inside City Limits			
uryland ta-f show	<u> </u>	MD Wicomico Sa	lisbury			1 Yes 2 No			
laryland Sa-f sho	둟	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	try?			
the M	Director	332 Cedar Drive	21804	ľ	USA				
with 18 231	<u></u>	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	an Indian, Black,			
eath iten	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.				
fter d 1", or	1.	3 Widowed 4 X Divorced If Yes, Give Year 155–59	1 Yes 2 No specify:		Specify: whi	to			
nurs a Itura	d by	45 December 10 Education (Considerable Indicated and Indicated) 400 December 10 Indicated Indica	cedent's Usual Occupation (Give kind of v		b. Kind of Business/In				
5-0036 led within 72 hou tygiene. other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use reti	red)					
036 ithin 7; ne.	ם	12 4	management		sales				
5-0 ed w fygie othe	S	17. Father's Name (First, Middle, Last)		(First, Middle, Maid					
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	Be	Ellsworth Gillispe Smith	Wilhelmi	na Marie	Scherhans				
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiest term 27 is marked other than "natural", or items 23a nr 28a-7 she traumatic event, the Medical Examiner must be notified at once	٦ 2	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or F	Rural Route Number	, City or Town, State,	Zip Code)			
MD d 2 sho lth and n 27 is			12 Old Ocean City R	oad Salis	sbury, MD	21804			
Te, 1 an Titer fiter			Disposition (Name of cemetery, or other place)	Date 20	Oc. Location - City or T	own, State			
Pages ent of		4 Donation 5 Other Specify:							
Baltimore, permit. Pages I ar Department of Hee Important: If ite Injory or nother to the Injory or nother tr		21. Signature of Funeral Price Long Fade, Director	22 Name and Address of Facility Boar	nd 655 W	Poltimore	Stroot			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other har injury or other traumatic event, the Medical		Similar Director	Baltimore, MD 212		Daitimore	Street			
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/Medical			faiture. List only one cause on each line. mediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease						
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al al	/Medical	■ MENDED □ AMENDED 23a,27 per	me g915 5-4-11 vt						
P.O. Box 68760, set that the death certificate be exigned by the attending physician be detached for use as the burial	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d, Date of delivery				
		23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregna		Month Da	y Year			
Box 68 c death certif the attending ed for use as	sici	4 Pregnant at time of death 5	Other (Specify)						
he de hed fe	Physiciar	Part II Other Joseph Conditions		Loop Didashar					
bed by detac	by F		ithe underlying cause given in Part I.		co use contribute to th				
S, F uires n sign Id be									
w red	Completed			24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of			
He lar	E			performed 1 ✓ Yes 2		2 No			
In: T		25. Was case referred to medical	26.Place of Death (Check of		-				
Division of Vital Records, P.O. Box 68 and or Attending Physician: The law requires that the death certificate death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp:	atient 3 DOA Other Nursing	g Home 5 Res	idence 6 🗸 Other:	Scene			
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on sath.	Ęį	Natural 5 Pending	1 Yes 2 No						
r Att r Att ter de rirect n by	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office building, etc.		et and Number or Rura	al Route Number, City			
urs af	Certification:	4 Homicide determined (Specify)		or Town, State)				
Hosp 24 ho Fune tely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and	due to the cause(s)	and manner as stated	1.			
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certi completely filled in by the funeral director	Medical	one) 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred a	the time, date and	place, and due to the	cause(s)			
E 3 E 8	₹	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Monti	h, Day, Year)			
		W)_m)	O.C.M.E.	A	pril 20, 2011				
		30. Name and address of person who completed cause of death (Item 23a)							
		Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MI	21201					
St.	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Regist	rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> April Physician/ Hunter R. Shettle, III 11:05 P M 28. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 6. Sex If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □XM 2 □ F Maryland Director 217-68-2766 56 Usual Residence of Decedent 28a-f shov 10b. County 10a State 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director Examiner must be notified Maryland Carroll Westminster 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 339 Bishop Court U.S.A. 21157 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces Black, White, etc. 0 þ 1 X Never Married 2 Married 2 XNo Ves Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: White Specify: "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event: the Man Elementary/Seconday (0-12) College (1-4 or 5+) Professional Bartender Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hunter R. Shettle, Jr. Janet Lambie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1554 Cottage Lane Charles P. Shettle / Brother Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Competery, crematory or other place)
Hilltop Service Corp. 5/4/2011 1 Burial 2 X Cremation 3 Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Se 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ alcohol disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 3 ☐ Ectopic pregrate
5 ☐ Other (specify) Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 V Other (Specify) WUSALQ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Fune

completed fil 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 204

Registrar

DHMH 17 Rev 7/2009

State

6101

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANVES

31. Date filed (Month, Day Year)

MAY 02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frances Smith April 5:15 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Raltimore Towson 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min. Feb. 10 Year) 1926 Mary land Director 2**19-18-7**036 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at Director 28a-f 1 ☐ Yes 2X No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21093 U.S.A. 41 Belmore Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces ?

1 Yes 2 No Black, White, etc. ö þ 1 Never Married 2 X Married within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Industry 12 Waitress Be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ပ Page 1 and 2 should be Emilie Levicek Dressal Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 21236 8624 Manorfield Road Nottingham, Maryland Thomas A. Smith Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dufatey cremetory protection Memorial Gardens 1 Durial 2 Cremation 3 Removal from State 4-29-2011 Timonium Maryland [†]Gärdens 4 Donation 5 Other (Specify) Ruck Towson Funeral 21. Si nature, f Full or Sex ice Lice Home, Inc. 22. Name and Address of Facility 21204 Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, If any, leading to in medicause. Enter Underlying Cause (Disease or iinjury TRIBIUM To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ 5 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident Suicide injury 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie D 19853 Name and address of person who completed cause of death (Item 23a) (Type, Print) HEMNEU GBMC N. CHARLES ST 32. Registrar's Signature filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 April 28. 8:15а м Ethel Sellman L. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harford 627 Sadler Street Aberdeen . Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 92 Months Days Hours 6/23/1918 Mary Tand Director 212-38-2397 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21001 627 Sadler St. or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. narked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Education Educator 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lauterbach Ethel Pearson permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Sadler St, Aberdeen, MD 21001 Ethel M. Sellman / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 5/3/2011 Beallsville Monocacy Cemetery any injury 4 Donation 5 Other (Specify) Sign de Fune Hervice Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, 333 S. Parke St. Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ STROKE disease or condition resulting in death) EW WEEKS Medical Due to (or as a consequence of Examiner YEARS ATRIAL FIBRILLATION HIN Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed CORONARY DISEASE and that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the buria Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) a 🗌 Unknown g Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ AGE 2 No 3 Probably 4 Unknown Completed page 2 should RENAL INSUFFICENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes within 24 hours a 'er death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) HOSPICE Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work? ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 0060532 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) 21001 ABERDEEN State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ FENYA SHNAYDERMAN 12:00P APR I Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE 3601 FORDS LANE, 9. Birthplace (State or Foreign Country) UKRAINE Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 01/02/1915 1 M 2XXF Months Hours 220-33-7322 96 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10d, Inside City Limits 10a. State with the Maryland other traumatic event, the Medical Examiner must be notified at Director BALTIMORE N/A MD 1 X Yes 2 - No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or Funeral USA 21215 3601 FORDS LANE, APT. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar man 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1XXNever Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) **EDUCATION TEACHER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည UNKNOWN CHANA SHNAYDERMAN VOLK0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7943 STARBURST DRIVE, BALTIMORE, MD 21208 VICTORIA FINKLER/GREAT-NIECE Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 04/29/2011 SOL LEVINSON & BROS., 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death Yes 1 ☐ Yes 21 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 2. Residence 6 Other (Specify) 욘 1 Inpatient 2 Inpatient 3 Inpa 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending work' 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide 124 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of stown RA#206 Balfi Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per verb., g915,05/.02/2011dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gentrude Teves Year Zoil 20 A M April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3925 Foley Quarter Road Ellicott City Howard 7. Age (In yrs. last birthday) 93 vrs If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 217-01-8457 Hours Min March 30,1918 Maryland Months Director Usual Residence of Decedent illy gene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No Maryland Howard Catonsville 10g. Citizen of What Country? 10f. Zip Code 21228 10e. Street and Number Funeral 6105 Chanceford Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify White If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Retail 10 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Kemstedt Augusta A. Reutz 19a. Informant's Name/Relationship (Type, Print)

Joan Cash/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3925 Foley Ouarter Rd., Ellicott City, Maryland, 21042 20a. Method of Disposition
1 X Buriat 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Meadowridge Memorial 4/30/2011 Elkridge,Maryland 4 ☐ Denation 5 ☐ Other (Specify) of Funera Service Lice 22. Name and Address of Facility 21. Signatur Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd. Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Lun (uncer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death 2 No Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed I e 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha lirector, page 2 2 | No 1 Tes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Daughter's Hospital 1 Yes 2 No Other 6 Other (Spec ျှ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA this #Residence 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred fter 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) hin 24 hours a the Funeral Dinpleted filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2

To the I

complex 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRAJAPAMEM.D DO057465 4/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-S- Rajapaks , MID Baltmon, MO. 2/209 2835 5min AV 5-703 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2011 April 1 12:30a M Physician/ N. Visser Hermanus Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Examiner Towson Blakehurst 8. Date of Birth (Month, Day, Year) April 20, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Holland 5. Social Security Number 6 Sex Days Hours Min. Funeral Months 1 K M 2 □ F 408-54-1369 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show 10b. County 10a. State "natural", or items 23a or 28a-f sho dical Examiner must be notified at by Funeral Director 1 Tyes 2 No Towson Baltimore MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21204 1055 W. Joppa Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after death Was Decedent Ever in U.S. Black, White, etc. Armed Forces Yes 2 X No 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 3 🔀 Widowed 4 🗆 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Tobacco permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Executive +218. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) Getrude Koch ပ Visser Hermanus N. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Hermans Nicholas Visser, Jr/son H. Nicholas Koch/ Son MD. 21204 1716 Killington Rd. Towson, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Towson, MD. 5-3-11 Hilltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Tacilityson Funeral Home, 1050 York Rd. Towson, MD. Signature Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea eupenekr Immediate Cause (Final 5/4eur Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): physician Physician/Medical Box 68760 IE EEMALE 23d Date of delivery 23b. Was decedent pregnant Year Month Day in the past 12 months? 1 Yes 2 No P.O. 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant condi<u>ti</u>ons** contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown δ prostate To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be a Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 KNO ည 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: injury 5 Pending 1 🔀 Natural 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Descriping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued to the cause(s) and the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) nurse Prestition 29c. License number 29b. Signature and title of certifier ((tem 23a) (Type, Print)

akekursh 1055 H. Joffa Road Sharon m. BeanCRNF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRIPBI SHARON M. KERW 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

HMH 17 Rev 7/2009

lener B. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02692 Christina Marie Wright State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day April 8, 2011 Year 1430 hrs Christina Marie Wright **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3 Franklin Square ICU Rosedale **Baltimore County** 00 5. Social Security Number If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Min Months Days Hours Director 219-27-1878 Oct.20,1977 Country)Maryland 1 M 2 X F 33 Usual Residence of Decedent 10a State Oc. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No 28a-f show Maryland Baltimore Baltimore items 23a or 28a-f shoust be notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4223 Kenwood Avenue 21207 U.S.A. Funeral 14. Race - American Indian, 8lack, 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 5 Specify: White Pages 1 and 2 should be filed within 72 hours after a ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", o or other traumatic event, the Medical Examiner I. 1 Yes 2 No specify: 3 Widowed 4 Divorced Yes, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. 11 Homemaker Own Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Wright, Jr. Patricia Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Wright, III 4223 Kenwood Avenue, Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4-16-11 Department c Ardent Cremation, Inc. Hanover, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Marzu o unera Cape, P.A. 21. Signature of Funeral Service Licenses marvelle mechael 6009 Harford Road, Baltimore, Maryland21214 23a. Part I. Enter the disease, permitted in the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Retween Onset and /Medical Death a. Sepsis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): b. Lower Extremity Cellulitis Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Phone after death.

Funeral Director: After this certificate has been signed by the attending physician and and cal AMENDED 23a-b, pt. II, 27, per me, g918 8-17-11 sm X UNPENDED ned by the attending physician detached for use as the burial ~ Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify, Physic 1 Yes 2 No 9 ✔ Unknown 9 Unknown page 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 ✔ Unknown Chronic drug use, hypertension, central nervous system Completed 24b. Were autopsy findings available 24a. Was an Vasculitis, Vernous Thrombi, Diabetes, Obesity autopsy prior to completion of cause of this certificate has performed? death? Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cent O.C.M.E April 9, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Harriet Warren Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Franklin Square Hospital Rose dale Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days 1 M 2 F Months Hours Min. **Director** 214-64-4339 55 Usual Residence of Decedent 28a-f show 10a, State 10b. County within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 Yes 2 No MD Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2108 Willow Spring Road, 1st Fl 21222 "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates njury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other tha Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl G. Oppel Jurina Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any Injury or other trau once. 8605 Bluestone Lane, Baltimore, MD 212

Date | 20c. Location - City or Town, State Earl Oppel - Brother MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Atlantic Crematory 4-30-11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature ul uneral Service Lica ee 22. Name and Address of Facility Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician/ ra Dreumoni Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Pregnant at time of death Year g Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 2 🗆 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physicfan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) der Re50000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD AZra 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygienes Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 AM Physician/ MEILA 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 5 PITAL ALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex Date of Birth Birthplace (State or Foreign **Funeral** Country 1 🗆 M 2 🗷 F Director Usual Residence of Decedent 28a-f show 10b. County 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Baltimore Yes 2 No ò 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a Funeral 2/215 rainor items 2 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō 2 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 "natural", Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
(OPFICE Administrator or other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important. If item 27 is marked any injury or other. Be 7. Father's Name (First, Middle, Last) Mother's Name (Fig., Middle, Maiden Surname, ၉ 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ruyal Route Number, City or Town, State, Zip Code) lto 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemeter 22. Name and Addre s of Facility or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Betweer val Between and Death Immediate cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury but to for as a consequence of and I-transit that the death certificate be executed that initiated events ing physician ar e as the burial-tı resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Por Month Day Year Pregnant at time of death detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 \(\sum \) Yes 2 No Accident Investigation completed filled in by the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMOR 21201 31. Date filed (Month, Day, Year) 32. istrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> April Physician/ George Η. Wirtz, Jr. 28, 6:30 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug 15, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 - F Months Hours Year) 930 212-26-3700 80 Mary Tand **Director** Vrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at death with the Maryland 10a, State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2410 Hartfell Road 21093 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2X No Specify: White "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Courier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wirtz, Sr. Adeline E. Carver Н. George traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 sh Betty R. Wirtz-wife item 27 2410 Hartfell Rd., Timonium, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Serv Corp 5/2/11 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home,, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) OARS Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year the 9 Unknown g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown After this certificate has been CHRONIC KIDNEY DISCASO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Tyes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence To the Hospital or Attending Pleatin 24 hours after death.

To the Funeral Director. After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending Accident Investigation □ Acciden
 □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier d address of person who completed cause of death (Item 23a) (Type, Print) 31. Dat filed (Month, Day, Year) 32. Registrar's Signature

√ DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 1:15 Ам Philip Yarnell, Jr. Medical Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death TOWSO MITT If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. **Director** 212-50-6028 Maryland Usual Residence of Decedent items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Maryland; ant. If fleen 21 is marked of ther than "natural", or items 23a or 28a-f sho ant. If fleen 21 is marked of ther than "natural", or items 23a or 28a-f sho urry or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl adical Examiner must be notified 1 Yes 2 X No Baltimore Baltimore MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1302 Kensal Court 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 K No Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 🗆 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11College (1-4 or 5+) Social Security Office Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Philip Yarnell, Sr. Vivian Heller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kensal Ct. Baltimore, MD. <u>Marlene Marie Yarnell/ Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spetth tombment 5-4-11 Parkville, MD. Moreland Mem. Park 21. Signature / uner Se/Fe Lic 22. Name and Address of Towson Funeral Home, Inc. 1050 York Rd. Towson. MD. 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dh, sician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours a " er decth. Cause (Disease or linjury signed by the attending physician and deedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) Yes a ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕅 No Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28d. Describe how injury occurred Natural N iniury 5 Pending 2 🗌 No Accident Investigation 24 hours a er deal Funeral Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2011 01

DHMH 17 Rev 7/2009

State

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Date filed (Month, Day, Ye

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State of Maryland / Department of Health and Mental Hygiene

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Ph Medical E	ysici				2. Date of Death		3. Time of Death			
Medical	ZXaIII	mer	Giovanni Zajcevski 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	Month Da April 24, 201	1 4c. County of Death	1748 hrs			
			Union Hospital	Elkton		Cecil				
	neral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda			/M/DD/YYYY) 9. Birth Foreign				
Dire	ector		216-54-4784 1∑M 2□F 59	Yrs. Months Days Hours Mi	Sept. 6.		ntry) Traly			
	*ny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits			
9	- ■	_	Maryland Boltings D. 1.11							
farylar	28a-f show	Director	10e. Street and Number	Citizen of What Count	1 Yes 2 No					
the N	23a or 28a-f sho notified at once.		3416 Sollers Point Road	21222	IIr	nited Stat	0.0			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hvoiene.	cms 2 t be n	Funeral		. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No-	14. Race - Americ White, etc.				
er dea	, nr it r mus		1 Yes 2 No	Yes 2 No specify:	- 1 11-21 1, 2 12 1					
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5 72 ho	en "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use re	tired)					
003 within	Medi	duc		-Employed		Contractin	g			
21215-0036 out be filed within 7	ed of	BeC	17. Father's Name (First, Middle, Last) Leonid Zajcevski		e (First, Middle, Maid	len Surname)				
212 Suld by	mari c eve		0	Anna U ailing Address (Street and Number or		, City or Town, State,	Zip Code)			
MD d 2 sho	n 27 is				Essex, Mar	vland 212	21			
ore, so I am	Important: If item 27 is marked other than "natural			sposition (Name of cemetery, or other place)	Date 20	c. Location - City or T	own, State			
Baltimore, permit. Pages 1 as Department of He	prof.		4 Donation 5 Other Specify: Entombment Holly	Hill Mem. Gdns	4/30/201	Middle R	iver, Md.			
Balt permit Depart	Impor		21. Signature of Funeral envice Licensee	2. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Avenue	Home of D	oundalk, I	ac.			
Physi	- 11		23a. Part I. Enter the disease, or complications that caused the death. Do not en	7922 Wise Avenue ter the mode of dying, such as cardiac	Dundalk. or respiratory arrest, s	Maryland shock, or heart	21222 Approximate Interval			
/Mec	dical		failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Injuries				Between Onset and Death			
jxam	mer		or condition resulting in death) Due to (or as a consequence of):				-			
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
		Examiner	cause. Enter Underlying Cause (Discass or injury that initiated c.							
uted	ld ransit		events resulting in death) Last Due to (or as a consequence of):							
e exec	physician and the burial - transit	Medical	UNPENDED AMENDED							
760 , icate b	physi the bu		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery				
Box 687 e death certific	ending use as	cian	past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	ancy	Month Da	y Year			
BO) e death	the attending pred for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown							
P.O.	signed by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		o use contribute to the				
JS, F	s been sign should be				24a. Was an		psy findings available			
COF	2	Completed			autopsy perform <u>ed</u>	prior to co death?	mpletion of cause of			
8 ਵ	his certificate director, page		25. Was case referred to medical	26. Place of Death (Check	1 Yes 2	No 1 ✓ Yes	2 No			
Vita ysicia	his cer direct	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 YER/Outpat			idence 6 Other:				
of and Ph	After		27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how i	njury occurred wheeled motorcy	vole struck			
SiOr Vitend death.	Director: in by the	catic	2 Accident Investigation	Tes 2 V No	guardrail and ej	ected				
Division of Vital Records, talor Attending Physician: The law requirers after death.	led in	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 2240 Pulaski Hwy, North East, MD							
Hospi	Funer tely fil		4 Unmicide (Specify) Major Road / Highw 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	Tn the Funeral completely filled	edical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.							
	- 3	ž	29b Signature and title of certifier	29c. License number		d. Date signed (Monta	h, Day, Year)			
			U-~ -	O.C.M.E.	Ar	oril 25, 2011				
			Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	00 W. Baltimore Street. Baltin	nore, MD 21223					
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
D	egisti	-22	MAY DO 2011 A							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011

	Please Type of Title III black indelible lik. Lisuie All Copies Are Legible.	
Harold Arthur Parks Armold, II	State of Maryland / Department of Health and Mental Hygiene	

		1- For State Certificate of Death		, ,	Reg	ı. No.		
Physicia ledical Examin	'n/	1. Decedent's Name (First, Middle,Last) Harold Arthur Parks Armold, Jr.		l M	ate of Death	Day Yea	ar	3. Time of Death 1907 hrs
		4a. Facility Name (if not institution, give street and number) 329 Hopkins Landing Drive 4b. City, Town, or Local Essex	cation of Dea	ath		4c. County Baltimor		
Funeral Director			Hours M	/lin.	2/18/		Foreign	hplace (State or n untry) Kansas
Aaryland 28a-f show any 1 at once.	tor	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Essex		***				10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f she		10e. Street and Number 10f. Zip Code 21221	l		100	j. Citizen of Wh		itry?
ter death w	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Property States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Sive Year of Dates: 13. Was Decedent of Hispani If Yes, specify Cuban, Me	lexican, Puer	rto Ricar	ı, etc.)	White S <i>pecif</i> y:	e, etc. WH]	
5-0036 led within 72 hours af Tygiene. Tygiene "matural" the Medical Examin	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years Electrical Engine	NOT use re	retired)	·	16b. Kind of Bu	ove:	ndustry nment
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than matic event, the Medical	e R	17. Father's Name (First, Middle, Last) Harold Arthur Parks Armold	Mother's Nar Doro	thy	Schol.	aiden Surname])	
ore, MD 2121 St 1 and 2 should be fit of Health and Mental if item 27 is marked her traumatic event,		Carolyn Torrence - Sister 10326 North 243	32 Circ	cle,	Weat	herford	l, OF	73096
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 injury or other traur		20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemete crematory or other place) Metro Crematory INC	04	_30_		20c. Location - Baltin	•	, Maryland
Baltimo permit. Pag Department Important: injury or of		22. Name and Address of Fatrik Fleming 22. Name and Address of Fatrik Fleming 23. Part I. Enter the disease or complications that cadsed the death. Do not enter the mode of dying, such	C.					Maryland 228 INC
Physician xaminer	î	failure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease)		c or resp	iratory arres	t, shock, or he	art	Approximate Interval Between Onset and Death
	iner I	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated						
ecuted and transit		events resulting in death) Last Due to (or as a consequence of): d.						
	Physician/medical	UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 4 Pregnant at time of death 5 Other (Specify) g Unknown	Ectopic preg	gnancy		23d. Date of Month		ay Year
S, P.O. I	ል	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given alcohol abuse	n in Part I.	_	1 Yes	2 No 3	Prob	the cause of death?
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should	Completed			- 1	24a. Was an autopsy perform ✓ Yes 2	/ F		topsy findings available completion of cause of
ital Resident The secretificate irector, page	2	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	·	ck only o		esidence 6	Other	Scene
on of V ading Phy: th. r: After thi	01:10	1 V Yes Z No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at				w injury occurr		
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the fineral director, page 2 should be detached for use as	Certification:	2 Accident 3 Suicide 4 Homicide Investigation Could not be determined Could not be determined (Specify)	ling, etc.		ocation (Str or Town, Sta		er or Rur	al Route Number, City
To the Hosp within 24 ho To the Fun completely f	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date are one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dear and manner stated.	eath occurred		ime, date ar	nd place, and d	lue to the	e cause(s)
		29b. Signature and title of certifier 29c. License nu O.C.M.E				April 27, 20		nth, Day, Year)
D V Sta		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, I 31. Date filed (Month, Day, Year)	Baltimore	e, MD	21223			
Registr		MAY 0 3 2011 Suma S. Jack				OCIME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 0329 AM APRIL Douglas Ernest Anderson Jr Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner AGNES SAINT HOSPITAL If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, 1**X** M 2 □ F Months Days Hours Min. 216-72-7531 Yrs Director Usual Residence of Decedent items 23a or 28a-f shov ier must be notified at 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No NA Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21207 1521 Kirkwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. id Mental Hygiene. marked other than "natural", or i matic event, the Medical Examin Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Merchandiser Home Depot 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary L. Williams Douglas E. Anderson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21207 Kirkwood Road, Baltimore, <u>Yelando Anderson-Wife</u> or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) King Memorial Park 5/7/2011 Woodlawn, Md 21. Si vature of Funeral Service Licensee any in Ma Name and Adores of Scillyt 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition nysician/ MYDIARDINE NEARLTION Medical resulting in death) Due to (or as a consequence of): Examiner VASCULLY UNKNOWN DROUPERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami UNICUOUN Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit LABET TYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical **B**dx 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g 🗌 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Yes 2 No s after deau... ral Director. After this ceru... "⊶ in by the funeral director, p." Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No မ 1 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D70718 28 MD 20/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 MARYLAND BALTIMORE. DARK 900 SOUTH CATON AVENUE 31. Date filed (Month, Day, Year) MAY 0 3 2011 2. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

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Educad Auston 11-02975

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Unk Unk	1- For State	tate of Marylar		rtment o		d Mental I	_	eg. No. 20	Name of the last o	13992
Physician/ Medical Examiner	1. Decedent's Name (First, Midd Edward Austo				.		2. Date of Dea Month April 20, 2	th Day Year		me of Death 014 hrs
	4a. Facility Name (if not instituti University Hospital	on, give street and num	ber)		4b. City, Town, or I Baltimore	Location of Dea		4c. County of N / A		
Funeral Director	5. Social Security Number unk	6. Sex 7.	Age (In yrs. las		If Under 1 Year Months Days	+	-	th(MM/DD/YYYY) 9/1979	9. Birthplac Foreign Country)	
ow any	Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Locat						Inside City Limits Yes 2 No
the Maryland a or 28a-f sh tiffied at once	MD 10e. Street and Number	N/A		В	altimor		1	Og. Citizen of Wha	at Country?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	731 W. Sarat 11. Marital Status 1 X Never Married 2 N	12. Was Deced	lent Ever in U.S es? 2 X No		as Decedent of Hisp es, specify Cuban,			U.S.7 14. Race - White,	American In	ndian, Black,
nours after d	15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grade	completed)	1 1 1 16a. Deceden	Yes 2X No	on (Give kind or	f work done	Specify:	Blac iness/Industr	
5-0036 ed within 72 hours yggiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) 10th Grade 17. Father's Name (First, Middle		or 5+)		structio	on	,	Constru Maiden Surname)	uctio	on Co.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple	Benjamin Bro	wn	-	19b. Mailing		Betty	Auston		 , State, Zip (Code)
e, MD t and 2 sho Health and item 27 is r traumati	Christina Au		20b. PI	ace of Dispos	N. Sarat		t., Bal	timore		
Iltimorial Pages Int. Pages Int. Pages Int. Pages Int. Int. Int. Int. Int. Int. Int. Int.	1 Burial 2 Crematio 4 Donation 5 Other S 21 Signature of Funeral Segment	Specify:	Julia	ematory or oth				Baltin		
Physician /Medical	23a Part I. 5 her the disease, or failure List only one cause	r complications that cause on each line.		214 Do not enter th	40 N. Fu	ulton .	Ave., E	Baltimon	re, M	PA D 21217 proximate Interval tween Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co								
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a co							_	
0, the executed sician and burial - transit	events resulting in death) Last UNPENDED	d AMENDED	orisequence ory.						_	
Sox 6876 leath certificate e attending phy for use as the	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	23c. If yes, out	t at time of deat	2 Fe	tal death 3 ner (Specify)	Ectopic pregr	nancy	23d. Date of d Month	elivery Day	Year
p. P.O. E rires that the c signed by the detached d by Phy	Part II. Other significant condi	tions contributing to d	eath but not res	ulting in the u	nderlying cause gi	ven in Part I.		bacco use contrib		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach prification: To Be Completed by P.				· - .			24a. Was a autop perfor	sy pri med? de		findings available tion of cause of
F Vital Rec Physician: The rr this certificate al director, page	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	11 2-1	atient 2 🗸 E	R/Outpatient		of Death (Check Other 4 Nurs		Residence 6	Other.	
Division of pital or Attending Phours after death. After filled in by the function Certification: Tertification:	27. Manner of Death 1 Natural 5 Pen	stigation	ay Year)	28b. Time of Ir 2338 hrs	1 Ye	es 2 🗸 No	28d. Describe h Subject was	now injury occurred shot	d	
Division o vith Hospital or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the funeral operation:	4 Homicide dete	rmined (Specify) S	Sidewalk		t, factory, office bu		or Town, Si 500 block of N	lorth Schroeder	Street, Bal	
To the How within 24 h To the Fun completely	(Check only one) 2 Medical Exa	hysiclan: To the best o miner: On the basis of e and manner state	examination and							e(s)
	29b. Signature and title of certific	hall Mi)			29c. License O.C.N			29d. Date signed April 20, 201		ay, Year)
_	30. Name and address of person Pamela E. Southall, N	MD Assistant Me	edical Exam	iner 11	1 Penn Street,	Baltimore,	MD 21201			
State Registrar	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	ake						
DHMH 17 Rev 1/2001	7 9 401	Value		ORIGINAL	L			nr.	AT**	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 84 2 7 2 2 3 y 20^{Year}1 Halimabai Sidik 3:30p. Ayub Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 333 Ellsworth Place Apt Joppa Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 - M 2x- F Months Days Hours Min (Month, Day, Year) Director 217-82-3308 86 02 East Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits MD Harford Joppa 1 Yes 2 X No 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 333 Ellsworth Place Apt Al 21085 U.S.A. Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Asian 3 XWidowed 4 Divorced 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Kasam Dada Amina Suleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. Mahomed Sidik-Son 962 Rumsey Place, Joppa, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Park 4/28/2011 Woodlawn, Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 shoc Interval Between Immediate Cause (Final Onset and Death Pmysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a surresqueries of): burial-transi Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown P.0. signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nyroidisn Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 - No 1 Yes I or Attending Physician: after death. 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗆 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural injury 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month) Day Year

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type,

Date filed (Month) Day, Year)

		Please							Are Legible.		
		State of Maryland / Department of Health and M 1- State Registrar Certificate of Death						2011 12001			
		1. Decedent's Name (First, Middle, Last)					Reg. No. 2 1 3 3 3 4 2. Date of Death 3. Time of Death				
Physicia /Medic		John Blakesley						April 30 2011 1:50 A			
Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Death		4c. County of Dea		
×		Charlestown Care Center Catonsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.					onsville I if Under 24 Hrs.	8. Date of Bir		Baltimore 9. Birthplace (State or Foreign	
Funeral Director		-	X M 2□F	80	Yrs.	Months Days	Hours Min.	Feb. 2	6, 1931	Indiana	
and w		Usual Residence of Decedent 10a. State 10b. County		10c, City.	Town or Lo	cation	*			10d. Inside City Limits	
Marylan -f show iled at	tor	,	imore	7,			onsville			1 ☐ Yes 2 No	
ours after death with the Mar rai", or items 23a or 28a-f st Examiner must be notified	Director	10e. Street and Number				10f. Zip Code	OHDVILLE		10g. Citizen of What Co	ountry?	
sath w		715 Maiden Choice	Lane, Rm.	HV61	2		21228			ates	
fter de ritem	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ▼ Yes 2 □ N If Yes, Give Year or Dates:				lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes of No Rican, etc.)	14. Race - Ame Black, Whi		
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nd 2 sl ulth an 27 is r r traur		Donna Dewey / Sis							er, City or Town, State, Indiana 4652		
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Page ment tant: It lury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Metr	o Cre	matory I	nc. 05/0	2/2011	Baltimore,	Maryland	
permit. Pages 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		21. Signature of Funeral Service Licen	see Alyson K	Tay1	or $\frac{22}{2}$	Name and Addre	ss of Facility Cr	emation	Society of	Maryland	
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eath certii attending for use a	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Tetonio nuovo			23d. Date of de	livery	
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has been signe 2 should b	Completed	246					24a. Was				
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Physician: Trithis certificate	Be	25. Was case referred to medical examiner?	Hospital:			t all DOA Oth	26. Place of Deat				
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or Att after de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At home. (Specify)	e, farm, stre	eet, factory, office		28f. Location (City or To	Street and Number or R wn, State)	ural Route Number,	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only (Ch									
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To t To t	Ž	29b. Signature and title of certifier	14/11	, ,	un	29c. Licens	e number	90	29d. Date signed (Mon	th, Day, Year)	
	-	30. Name and address of person who o	omnieted cause of de	agth (Item 2	3a) (Typo	Print)	•		11.301	4	
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1-03100		Please Type or Print in Black Indelible Ink. Ensure All Copie		gible.					
ulius Beyer		State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death		201	1399				
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat	eg. No.	3. Time of Death				
Priysicia µedical Examii		Julius Edward Beyer	Month April 23, 2	Day Year 011	2131 hrs				
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 703 Cedar Avenue Glen Burnie		4c. County of Death Anne Arundel					
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	. 8. Date of Bir	th(MM/DD/YYYY) 9. Birt	hplace (State or				
Funeral Director	- 1	216-29-5776 1x1 M 2 F 22 Yrs. Months Days Hours Min.	7	Foreig	n ^{intry)} Maryland				
	ŀ	Usual Residence of Decedent	Thee.	- 17001					
yna		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
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r dea	ᆵ	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specific L.TI	nite				
rall'	Š	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	vork done	Specify: W] 16b. Kind of Business/li					
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5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, N		5				
21215-0036 ould be filed within 72 hours after death with the Maryland I Mental Hygiene. narked other than "natural", or items 23a or 28a-f ahe ic event, the Medical Examiner must be notified at once	Be		Fay Hay						
MD 21215-0036 42 should be filed within 7 th and Mental Hygiene. a 27 is marked other than umatic event, the Medica	유	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			Zip Code)				
MC and 2 s afth an m 27 aum.	_}	Lorrain Latimer Beyer/Grandmother 703 Cedar Ave. G. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	len Buri	nie, MD 2	1061				
ore, s l a of He of He		1 Burial 2 Cremation 3 Removal from State crematory or other place)	Date	200. Education - City of	Town, State				
Page ment tant:		4 Donation 5 Other Specify: Glen Haven Mem. Park 4/2	9/2011	Glen Burn	ie, Maryland				
Baltimore, MD 21215 permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, th	- 1	21. ignature of Fun al Service Licensee 22. Name and Address of Facility Kirkley-Ruddick For 421 Crain Hwy. SE	uneral I	Home, P.A.					
	-4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	Glen	Burnie, MD	21061 Approximate Interval				
Physician /Medical		failure. List only one cause on each line.			Between Onset and Death				
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be experimental	ğ	☐ AMENDED 23a,27,28a-f,per me,g916 6-22-	II Sm						
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Box 68760, e death certificate be the attending physic ed for use as the bur	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of the past 12 months? 1								
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COT law re has b	ם			rmed? death?	ompletion of cause of				
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irecto	Be	examiner? Hospital: 4 Insertingly 2 ER/Outpetient 3 DOA Other, Nursing		Residence 6 🗸 Other	Scene				
1 of Vital Records, ling Physician: The law require After this certificate has been si funeral director, page 2 should h	Ê	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		now injury occurred					
C# _ `#	톍	1 Natural 5 Pending fd 4-23-11 fd 9:00 pm 1 Yes 2 No	Unknown						
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Dipital ours a filled I	Ser	4 Homicide determined (Specify) Found at Residence	Homicide determined (Specify) Found at Residence Glen Burnie, Md.						
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the caus	the cause(s) and manner as stated.					
To the within To the comp	Medical	29b. Signature and title of certifier 29c. License number	,	29d. Date signed (Month, Day, Year)					
		O.C.M.E.		April 24, 2011	,,,				
		30. Name and address of person who completed cause of death (Item 23a)							
<		Margarita Korell MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re, MD 2122	3					
St	ate	31. Date filed (Month, Day Year) 32 Registrar's Signature							
Danial		DI IV T T T T T T T T T T T T T T T T T T							

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		1- State Registrar	9137,65 <i>7683</i> Cer	Tanent of Health and tificate of Death	Mental Hygie		1399		
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Inocencio	Imoris	2. Date of Death	Day, 2011 09:53 M				
Examine		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age	(In the second of the second o	4b. City, Town, or Location of Deat Baltimore City If Under 1 Year If Under 24 Hr		4c. County of Death	place (State or Foreign		
Funeral Director		5. Social Security Number 5. 46-62-5143 Usual Residence of Decedent	(In yrs. last birthday) 69 Yrs.	Months Days Hours Min		ar) 1941 Phil	ippines		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Meportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Insid							
	al Director	10e. Street and Number 13619 Oaklands Manor Drive	10f. Zip-Code	Citizen of What Coul	ntry?				
	by Funeral	11. Marital Status 1 □ Never Married	ver in U.S. 13.	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	etc.		
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	To Be Col	12th 3 1/2 Engineering Technician NOAA 17. Father's Name (First, Middle, Last) Felipe Balmoris 18. Mother's Name (First, Middle, Maiden Surname) Mamerta Embat							
d 2 shou th and M 7 is mar traumati		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		Nelita Balmoris/Wife 20a. Method of Disposition 1 🖁 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 200	Location - City or Ti			
permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707							
Physician /Medical cian and pnuial-transit	dical Examiner	23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one daute on each line. Immediate (aute (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death Due to (or as a consequence of): 5. 5. 5. 5. 5. 5. 5. 5. 5. 5							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					23d. Date of delivery Month Day Year		
quires that the signed by all the detact	β	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 3 Probably 4 Unknown							
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I or Attending after death. Director: Afte d in by the fur	Certification:	1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending investigation 5 Natural 5 Pending investigation 6 Could not be determined 6 Suicide 6 Could not be building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office 5 Sec. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
he Hospita in 24 hours he Funeral ipletely fillec	edical	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
Vith vith Con.	Σ	29b. Signature and title of certifier Rush Kushnasuran	-	29c. License number ReS - COO		Date signed (Month)	Day, Year) 2 2011		
3+11		30. Name and address of person who completed cause of de RUPA KRISHNASWAMY		600	North Wolfe	St, Baltimo	re, MD, 2128		
Stat Registra		31. Date filed (Month, Day, Year) — Gistrar's MAY 0.3.2011	s Signature	Kel					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g915 5-3-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29^{Day} Physician/ April 20111 George E. Bornman Jr. 3:28a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 58 Perry Falls Place Nottingham Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, E Sept 1 🛛 M 2 🗆 F Hours Min 57 Director 219-62-1429 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Nottingham 1 🗌 Yes 2 🛣No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 58 Perry Falls Place 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Specify: White 3X Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Press Operator Zap Printing 12+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental ? 2 George E. Bornman Sr. Patsy Joy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Bornman III /son 356 Endsleigh Ave. Balto. MD 21220 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. of 1 ☐ Burial 2 【★Cremation 3 ☐ Removal from State Bayview Crematory 5/3/11 4 Donation 5 Other (Specify) Baltimore MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility 300 Mace Ave. Balto. MD alun Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e Immediate Cause (Final Physician/ disease or condition Medical resulting in death) uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year the g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ह्य 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director, After this upleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No ✓ Natural 5 Pending ☐ Acciden☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check celtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month, Day, Year) 0 1061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rafael Perez-Mera 777 Reisterstown Rd. Suite 222 Pikesville, Md. 21208

State Registrar egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Peggy Ann Bowles 201 8-00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Season Hospice Randallstown Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan • 26 • 1939 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F Months Days Hours Country) Director 72 215-38-7263 DC Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15408 Clayburn Drive 20707 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2XXMarried 1 ☐ Yes 2 K No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 1.2 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Andrew Jackson, Sr. Bertie Jane Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Francis Robert Bowles/ Husband 15408 Clayburn Drive, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 30, 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St.Mary's Cemetery 2011 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Je Kein Stila M01053 313 Talbott Ave., Laurel, MD 20707 Ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final -Dhysician/ stage dementia disease or condition 20-Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2* No 1 Yes 2 = 9 Unknown 9 Unknown P.0. or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş sign Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed ☐ Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) tapt Haspite 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1-Natural 5 \square Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 1 Tes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: The basis of my included and include the final date and place, and due to the cause(s) and manner as tated. (Check nly an 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D34053 m

State Registrar 31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

bach

1/2

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 13999 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Michael Physician/ Boyce ^{Day} 2011 Month Ам May 5:30 Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Timonium** Examiner Stella Maris Hospice 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 5. Social Security Number 218-58-9577 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**M 2 □ F Months Days Hours Min. 0470171954 Country) **Director** MD Usual Residence of Decedent show 10b. County or 28a-f shorn 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? rms 23a or ò 10f. Zip Code Funeral 910 North Marlyn Avenue 21221 . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Disabled N/A traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Veronica Shanheltz 2 Ray Ralph Boyce 2011 ^{19a.} Informant's Name/Relationship (*Type, Print*) Roberta Koble / Sister 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State Zip Code) 1964 Chipper Drive, Edgewood, MD 21040 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem 5/3/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Maryland Cremation Services
PO 3ox 1413, Baltimore, MD (Funeral Service License Porota Marshal) 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ BLADDER CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impory burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown Division of Vital Records, P.O. þ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ate has by autopsy performed this certificate Yes 2 🔀 No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 **X** Other (Specify) **HOSPICE** 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7 Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Sinature Registrar

JAMES BOYCE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 27ay **Physician** 2011 10:30 PM /Medical 4a. Facility Name (If not Institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 23150 Harrison Road Deal Island Somerset 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days 006-32-6834 1 □ M 2 KF Hours Director NH Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f shov ner must be notified at MID Somerset Deal Island Director 1 TXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23150 Harrison 21821 Road USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2€ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William I. Farrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Clarence Barrett, Jr./Spouse 23150 Harrison Road, Deal Island, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ @remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem, 4/30/2011 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No nas page 2 autopsy perform certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 □ Pending investigation Iniury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of eted cause of death (Item 23a) (Type, Print)

Registrar
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State

31. Date filed (Month, Day,

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